

Manley Services  
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**FLEXIBLE SPENDING ACCOUNT  
FLEXIBLE COMPENSATION ENROLLMENT FORM**

Employer \_\_\_\_\_ Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
Eligibility Date

Employee Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employee Mailing Address (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

Primary Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

Payroll Deducted Group Insurance Premiums?  Yes  No  N/A If yes, \$\_\_\_\_\_ per pay period

I request the following amounts(s) to be reduced per pay period:

	<b>Per Pay Period Amount</b>	<b>Annual Amount</b>
Unreimbursed Eligible Health-Related Expenses	\$ _____	\$ _____
Dependent Care Expense(s)	\$ _____	\$ _____
Other Health Related Insurance Premiums	\$ _____	\$ _____
Administrative Fee	\$ _____	\$ _____
<b>TOTAL AUTHORIZED REDUCTIONS</b>	<b>\$ _____</b>	<b>\$ _____</b>

I hereby certify the above information to be correct and true to the best of my knowledge and that the children on whom I will be claiming dependent expenses or child care, either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amount remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provision and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment. I also understand that the above reductions may correspondingly reduce my future Social Security Benefits.

**UNREIMBURSED HEALTH-RELATED EXPENSES  
PREMIUM COMPLETION AGREEMENT**

I am agreeing to participate in the Unreimbursed Health Expense account for the entire Plan Year. I understand that if my employment were terminated the remaining monthly premiums will be taken from my final paycheck on a pre-tax basis; or in the alternative (I) agree to reimburse my employer (on a monthly basis) with after-tax dollars. If my final paycheck does not cover the remaining contributions I agree to reimburse my employer the remaining balance. I further understand that I have through the end of the Plan Year to incur eligible expenses, and may request reimbursement through the end of the normal run-out period as described in the Summary Plan Description.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Manley Services is a PacificSource company. PacificSource and Manley Services may request and exchange information to facilitate your enrollment in a Flexible Spending Account.*