

**Dependent Day Care
Flexible Spending Account
Enrollment/Change Form**



INITIAL ELECTION CHANGE TERMINATION

EMPLOYEE INFORMATION

EMPLOYEE SOCIAL SECURITY NO. <i>(Required)</i>		EMPLOYER NAME <i>(Required)</i> Associated Universities, Inc. (NRAO) -	
EMPLOYEE LAST NAME		EMPLOYEE FIRST NAME	M.I.
EMPLOYEE ADDRESS			
CITY		STATE	ZIP/POSTAL CODE

PRE-TAX FLEXIBLE SPENDING ACCOUNT

Choose the annual amount you would like to have withheld from your salary and placed into a Dependent Day Care Flexible Spending Account for reimbursement of eligible dependent day care expenses.

Annual Amount Elected:
\$ _____
(not a per pay period amount)

Annual amount elected will be divided by the number of pay periods in the Plan Year.

AUTHORIZATION

I hereby authorize my employer to reduce my earnings by the amount stated above for deposit into my Dependent Day Care Flexible Spending Account and to make this money available to me for the reimbursement of dependent day care out-of-pocket expenses as appropriate.

I understand that I will forfeit any unused balance in my account at the end of the Plan Year. I also understand that I cannot change my plan participation during the Plan Year unless I have a change in family status, as defined in the Regulations under Internal Revenue Code Section 125.

SIGNATURE	DATE
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FOR EMPLOYER USE ONLY *(Required)*

EFFECTIVE DATE	ACCOUNT NUMBER -	BRANCH NAME	BRANCH CODE	ER AAE
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