



**EMPLOYEE REIMBURSEMENT ACCOUNT PROGRAM
JANUARY THROUGH DECEMBER 2012 ENROLLMENT FORM**

Open Enrollment Deadline: December 9, 2011

Return Completed Form To:
BENEFITS ADMINISTRATION
 500 Griswold Street, Suite 900
 Detroit, MI 48226
 Phone: (313) 224-7721
 Fax: (313) 967-1228
 E-mail: benefits@co.wayne.mi.us

EMPLOYEE INFORMATION			
Employee ID		Plan Year	01/01/2012 through 12/31/2012
Employee Name		ERA Effective Date	01/01/2012
Address		Deduction Begin Date	01/14/2012
City, State, Zip		Date of Hire	
Daytime Phone		Date of Birth	
E-mail Address		Employee SSN	

EXTENSION PERIOD: Wayne County's plan includes the IRS extension period. The extension / grace period allows for reimbursement of claims incurred within the first 2 1/2 months of the next plan year using any funds remaining from the previous plan year. Thus, claims incurred during the period beginning January 1st through March 15th, 2013 and submitted by March 31, 2013 may be reimbursed with any unused funds remaining in your account from the previous plan year (01/01/2012 - 12/31/2012).

TERMS OF ENROLLMENT / AGREEMENT

As an eligible participant in the Cafeteria Plan, I acknowledge that I have received the Employee Reimbursement Account Program Summary Plan Description (SPD). I have read the SPD and understand the benefits available to me as well as the other rights and obligations that I have under the Plan. In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the plan year or during such portion of the year as remains after the date of this agreement.

ELECTION OF HEALTHCARE EXPENSE REIMBURSEMENT PROGRAM

I elect to receive healthcare expense reimbursements for the plan year. I understand that:

- Reimbursements will be available only for "qualifying healthcare expenses" as described in the SPD. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate at the end of the stated plan year, upon termination or discontinuation of the Plan, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of the redirection.

Amount of annual compensation redirection for healthcare reimbursement: \$ _____ for the 2012 plan year

which is \$ _____ per pay for the 26 pay periods remaining in this year.

\$6,000 plan year maximum

ELECTION OF DEPENDENT CARE EXPENSE REIMBURSEMENT PROGRAM

I elect to receive dependent care expense reimbursements for the plan year. I understand that:

- Reimbursements will be available only for "qualifying dependent care expenses" as described in the SPD. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate at the end of the stated plan year, upon termination or discontinuation of the Plan, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of the redirection.

Amount of annual compensation redirection for dependent care reimbursement: \$ _____ for the 2012 plan year

which is \$ _____ per pay for the 26 pay periods remaining in this year.

\$5,000 plan year maximum

ELECTION OF ADOPTION EXPENSE REIMBURSEMENT PROGRAM

I elect to receive adoption expense reimbursements for the plan year. I understand that:

- Reimbursements will be available only for "qualifying adoption expenses" as described in the SPD. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate at the end of the stated plan year, upon termination or discontinuation of the Plan, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of the redirection.

Amount of annual compensation redirection for adoption reimbursement: \$ _____ for the 2012 plan year

which is \$ _____ per pay for the 26 pay periods remaining in this year.

\$12,170 plan year maximum

ELECTION OF PARKING EXPENSE REIMBURSEMENT PROGRAM

I elect to receive parking expense reimbursements for the plan year. I understand that:

- Reimbursements will be available only for "qualifying parking expenses" as described in the SPD. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate at the end of the stated plan year, upon termination or discontinuation of the Plan, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of the redirection.

NOTE: You CANNOT enroll in the Parking Expense Reimbursement Program if you are currently having your monthly parking fees payroll deducted through Wayne County payroll.

Amount of annual compensation redirection for parking reimbursement: \$_____ for the 2012 plan year

\$230 per month maximum

which is \$_____ per pay for the 26 pay periods remaining in this year.

ELECTION OF COMMUTER TRANSIT EXPENSE REIMBURSEMENT PROGRAM

I elect to receive commuter transit expense reimbursements for the plan year. I understand that:

- Reimbursements will be available only for "qualifying commuter transit / van pool expenses" as described in the SPD. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate at the end of the stated plan year, upon termination or discontinuation of the Plan, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of the redirection.

NOTE: You CANNOT enroll in the Commuter Transit Reimbursement Program if you are currently having your monthly commuter transit fees payroll deducted through Wayne County payroll.

Amount of annual compensation redirection for commuter transit reimbursement: \$_____ for the 2012 plan year

\$230 per month maximum

which is \$_____ per pay for the 26 pay periods remaining in this year.

DESIGNATION OF BENEFICIARY

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek the payment of benefits under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

NAME: _____ Relationship: _____ Phone: _____

Debit Card(s) Available for Participants Enrolled in a Healthcare Expense Reimbursement Account*

Please indicate if you wish to have the card(s) sent to you, your spouse and college-aged child: Yes No

Spouse's Name: _____ Child's Name(s): _____

* An annual debit card fee of \$12.50 per participant (employee) will be charged.

OTHER TERMS AND CONDITIONS

I understand that:

- I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he/she believes it to be advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The redirection of my cash compensation under this agreement shall be in addition to any redirection under other agreements or benefit plans.
- The amount of my compensation redirection(s) will be credited to an insurance, health care, dependent care, adoption, parking, and/or commuter transit / van pool expense reimbursement account and such amount will be paid on my behalf or I will be reimbursed, up to the amount which I have elected to redirect to the Cafeteria Plan, for the applicable expenses incurred during the year.
- Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year (except as provided for during the IRS extension period described previously).
- My Social Security benefit may be slightly reduced as a result of my election.
- I hereby consent to the use of my personally identifiable information, and or my dependent(s)' information, which I have voluntarily provided in this form. I also hereby consent to the use of any protected health information I have furnished on my behalf, or my dependent(s)' behalf, for the sole purpose of providing benefits, services, or any information I have requested.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN AND/OR HEALTHCARE, DEPENDENT CARE, ADOPTION, PARKING AND COMMUTER TRANSIT / VAN POOL EXPENSE REIMBURSEMENT PLANS, AS AMENDED FROM TIME TO TIME, IN EFFECT AND SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDIRECTION AGREEMENT RELATING TO SUCH PLAN(S).

Employee Signature: _____ Date: _____

Accepted and agreed to by the Wayne County P/HR Benefits Administration Division authorized representative:

By: _____ Date: _____