JEFFERSON FEDERATION OF TEACHERS HEALTH AND WELFARE FUND
P. O. BOX 6137 ◆ METAIRIE, LA 70009-6137 ◆ (504) 455-7261 ◆ FAX (504) 455-7267

HEALTH CARE FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM AND SALARY REDUCTION AGREEMENT FOR PLAN YEAR SEPTEMBER 1, 2005 THROUGH AUGUST 31, 2006

Please complete and return this form to the Fund Office at the above address to be **received no later than August 31, 2005**. If you are enrolling as a newly eligible Employee, this form must be received **before the end of your Waiting Period**.

If not received by that time, the Fund must assume you do not wish to reduce your salary for the 2005-2006 Plan Year.

ENROLLMENT INFORMATION (PLEASE TYPE OR PRINT)

Name of Employee

_____

(Last) (First) (Middle)

_____ _____

Social Security Number Employee Number

As an eligible employee in the JFT Health and Welfare Fund Flexible Spending Account Plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

In accordance with my rights under the Plan, I hereby authorize the Jefferson Parish School Board to reduce my salary by the amount indicated below for the 2005-2006 Plan Year to reimburse me for expenses incurred in the period September 1, 2005 - August 31, 2006. I further authorize the School Board to make such payroll deductions from my salary, prorated over the number of consecutive pay periods in the Plan Year, and to forward them to the JFT Health and Welfare Fund.

Your maximum and minimum reduction amount for the 2005-2006 Plan Year is:

- If enrolling during the Enrollment Period (July 1, 2005 through August 31, 2005), the minimum election for the Plan Year is $180.00. The maximum election is $4,200.00.
- If you are a newly eligible Employee enrolling during your Waiting Period, the minimum election for the Plan Year is $15.00 per month for each month remaining in the Plan Year. The maximum election is $350.00 per month for each month remaining in the Plan Year. (Example: An Employee whose eligibility began November 1, 2005. From November through the end of the Plan Year there are 10 months (November-August) left in the Plan Year. The minimum election is $150.00. The maximum election is $3,500.00.)

Total Plan Year Salary Reduction Amount for my Health Care Flexible Spending Account : $_____

Total Annual Amount

I agree and understand that:

Reimbursements will be available only for "qualifying medical care expenses" as provided in the Summary Plan Description.

This election form cannot be revoked or changed during the Plan Year except in specific circumstances permitted by the Plan, and then only if consistent with the terms of the Health Care Flexible Spending Account Plan and made on account of and consistent with a change in family status.

Salary reductions must be reimbursed for expenses incurred during the Plan Year and may not be carried over into future Plan Years. If at the end of the 2005-2006 Plan Year, the total reduction in compensation exceeds the eligible expenses, the difference in amounts will be forfeited to the Plan.

I have examined this Agreement and to the best of my knowledge, it is true, correct, and complete.

_____

Signature Date

_____

Witness Signature (**Claim will be returned if not Witnessed – Must be 18 years or older to witness**) Date