

SAINT MICHAEL'S COLLEGE FLEXIBLE BENEFITS PLAN

Dependent Day Care Expense Claim Form

Name (last, first, MI)	Social Security #
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Name of Dependent(s):

Period of Care: _____ through _____

Amount Requested (care provider complete Affidavit section below or attach receipts or invoices):

Service Provider Information

Name:

Address:

Provider's Tax ID# or Social Security #:

Description

Affidavit of Dependent Care Services Rendered

I have provided adult/child care for _____ for the period beginning _____

and ending _____. Services were provided to _____ for a fee of \$_____

Signature of Care Giver _____ Tax ID# or SS# _____ Date _____

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E** The total amount claimed under the plan must not exceed the lesser of your wages or salary for the plan year, or the wages or salary of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of \$200 if there is one child or dependent, and \$400 if there are two or more.) No payment may be made under the plan if the service provider is your dependent for federal income tax purposes, or is your child or stepchild and is under age 19.

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T** The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period in which the undersigned was covered under the Saint Michael's College Flexible Benefits Plan with respect to such expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal and state income taxes and social security taxes on amounts paid from the plan which relate to such expense. The undersigned further understands that no dependent care tax credit is permitted for amounts for which reimbursement is made.

Participant's Signature	Date
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Please return completed form to:

Future Planning Associates, Inc.
ATTN: Saint Michael's College Administrator
600 Blair Park Road, **P.O. Box 905**
Williston, Vermont 05495-0905

FAX: 802/878-9455 – If Faxing this request, to avoid duplication, DO NOT mail.

Direct Deposit for Claims Reimbursement is available -- check this box and complete the "Employee Authorization Agreement for Direct Deposit..." and send to Future Planning Associates, Inc.
•only one request is needed to implement this service•

• This form must reach Future Planning Associates, Inc. by noon on the 25th of each month •
•Disbursements are paid the following month •

Saint Michael's College Flexible Benefits Plan Revocation of Benefit Election and Compensation Redirection Agreement

Name (last, first, MI)		Social Security #	
I hereby revoke my benefit election and compensation redirection agreement under the Saint Michael's College Flexible Benefits Plan with respect to the following coverage(s):			
Non-Insured Coverage		Insurance Coverage	
<input type="checkbox"/> Health Care Expense Reimbursement <input type="checkbox"/> Dependent Care Assistance		<input type="checkbox"/> Health Insurance	
Change in Status		Change In Status continued	
<input type="checkbox"/> Dependent Care cost change due to change in provider or fees (fee change not applicable if care provider is a relative) <input type="checkbox"/> Spouse 's or dependent's change in coverage under their employer's cafeteria or other qualified plan (change is not applicable to the health care reimbursement account) <input type="checkbox"/> Your, your spouse's or dependent's change in eligibility for Medicare or Medicaid		<input type="checkbox"/> Marriage, Divorce, Annulment <input type="checkbox"/> Spouse or dependent dies <input type="checkbox"/> Birth, Adoption or Placement for Adoption <input type="checkbox"/> Your, your spouse's or dependent's employment status changes <input type="checkbox"/> Dependent's status changes <input type="checkbox"/> Your, your spouse's or dependent's change in residence or worksite <input type="checkbox"/> My spouse or I take an unpaid leave of absence	
This revocation is to be effective with paycheck date:			

I understand that the change in my benefit selection must be necessitated by and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury. My benefit election and compensation redirection agreement shall remain in effect as to my benefit coverage(s), if any, which are not checked above. I understand that this revocation may not be effective prior to the first day of the next plan year unless it is made because of a change in (family) status as defined in the Plan. In no event may the revocation be effective prior to the first pay period beginning after this form is completed and returned to the Plan Administrator.

I certify that I am making this election because of the change in (family) status indicated above.

Employee's Signature:	Date:
Accepted and Agreed to By:	Date:

Dependent Care Assistance Account Worksheet

Use this worksheet to estimate your tax savings with the Dependent Care Assistance Account and compare to your tax savings under the Federal Dependent Care Tax Credit. Please note, this is a general worksheet. Consult your tax advisor if you have questions about your individual situation.

Income and expenses

- a) Enter your total annual income (for you and your spouse, if applicable) before taxes but after deductions (a) \$ _____
- b) Enter the estimated cost of child and dependent care for the upcoming year (b) \$ _____

Dependent Care Assistance Account Tax Savings

- c) Determine your estimated Federal and Social Security/Medicare tax rate:

Enter your estimated Federal income tax rate: _____%

Enter your estimated State income tax rate: _____%

Add 7.65 if your estimated income is \$80,400 or less (for 2001)*: _____%

Add 1.45 if your estimated income is greater than \$80,400 (for 2000)*: _____%

Your estimated total Federal, State, and Social Security/Medicare Rate (sum the above percentages and enter on (c): _____% (c) \$ _____%

- d) Enter the amount in item (b). If married, you may not claim more than the earnings of the lower paid spouse. The maximum amount that can be claimed is \$5,000 per year (\$2,500 if you are married and filing separately). Special rules apply to employees with spouses who are incapacitated or are full-time students at least five months during the calendar year: (d) \$ _____
- e) Multiply the expenses in item (d) by the percentage in item (c) to estimate the tax savings from the Dependent Care Assistance Account: (e) \$ _____

(continued on next page)

* The 2001 Social Security Tax is 7.65% of the first \$80,400 of taxable earnings. On earnings in excess of \$80,400, the Social Security Tax is reduced to 1.45%.

Federal Child and Dependent Care Tax Credit

- f) Enter the amount in item (b) subject to the following maximums:
If one child or dependent: \$2,400; if two or more, \$4,800; if married,
you may not claim more than the earnings of the lower paid spouse: (f) \$ _____
- g) Based on the total gross annual pay you and your spouse (if any)
earn, select the appropriate tax credit from the table below: (g) \$ _____

Total Gross Annual Income	Tax Credit
Up to \$10,000	30%
\$10,001 to \$12,200	29%
\$12,001 to \$14,000	28%
\$14,001 to \$16,000	27%
\$16,001 to \$18,000	26%
\$18,001 to \$20,000	25%
\$20,001 to \$22,000	24%
\$22,001 to \$24,000	23%
\$24,001 to \$26,000	22%
\$26,001 to \$28,000	21%
\$28,001 and Up	20%

- h) Multiply item (f) by the percentage in item (g) to estimate the
Federal Child and Dependent Care Tax Credit: (h) \$ _____

Making Your Decision

Compare item (e) to item (h). If the tax savings in (e) is greater than the Federal Tax Credit in (h), your Dependent Care Assistance Account will save you more money than the Federal Tax Credit. If the Federal Tax Credit in (h) is greater than the Dependent Care Assistance Account tax savings in (e), then you should not enroll in a Dependent Care Assistance Account. Be sure to talk to a tax advisor if you have any questions about your individual situation.

Summary

A Dependent Care Assistance Account is easy to use and can save money starting with your first paycheck. Unlike the child and dependent care tax credit, which is not available until you file your federal return, a Dependent Care Assistance Account reduces your taxable income right away. And, in most cases, the savings from a Dependent Care Assistance Account exceed the savings from the federal tax credit. Please note: tax savings may not be the only factor to consider when making this decision.

Notes:

- 1) You may use a combination of the Assistance Account and tax credit. However, any amount you deposit to the Assistance Account will be deducted from the maximum you are eligible to use in claiming a tax credit.
 - 2) Services must be provided for someone under age 13 or a qualified* dependent (including eldercare).
 - 3) If you take advantage of either the Assistance Account or the tax credit, you must provide the name, address, and taxpayer identification number of your dependent care provider on your reimbursement form and on your annual federal tax return.
 - 4) If you contribute to a Dependent Care Assistance Account, your employer will include your dependent care reduction on your Form W-2 for IRS reporting purposes only. This amount is tax free. You will need to submit IRS Tax Form 2441 (parts I and III) each year if you participate in the Dependent Care Assistance Account.
- Over the age of 12 (either a child or dependent adult) and physically or mentally incapable of self-care.

**EMPLOYEE AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF
HEALTH CARE AND DEPENDENT CARE REIMBURSEMENTS**

I hereby authorize and request that Future Planning Associates, Inc. (contracted by Saint Michael's College to provide administration services for the Saint Michael's College Flexible Benefits Plan) to make payment of any Saint Michael's College Flexible Benefits Plan Claims Reimbursement of any amounts to me by initiating credit entries to my account indicated below in the bank named below, hereinafter called BANK, and I authorize and request BANK to accept any credit entries initiated by Future Planning Associates, Inc. to such account and to credit the same to such account without responsibility for the correctness thereof.

I also authorize Future Planning Associates, Inc. to adjust any over deposits erroneously credited to my account if prior to the initiation of the correcting entry, Future Planning Associates, Inc. has sent or delivered to me written notice of the correction.

It is understood that this agreement may be terminated by me at any time by written notification to Future Planning Associates, Inc. Any such notification to Future Planning Associates, Inc. shall be effective only with respect to entries initiated by Future Planning Associates, Inc. after receipt of such notification and a reasonable opportunity to act on it. Any such notification to BANK shall be effective only with respect to entries credited to my account by BANK after receipt of such notification and a reasonable time to act on it.

I recognize, acknowledge and accept that this service is being provided for my convenience. As such, I agree not to hold Saint Michael's College and Future Planning Associates, Inc. liable for errors made by them or the financial institution.

ATTACH A VOIDED CHECK OR DEPOSIT SLIP FOR SAVINGS ACCOUNTS

Name of Bank or Credit Union * _____

Account # _____ Routing # _____

* Contact your Credit Union to verify your "Account" and "Routing" Numbers

Account Type: _____ Checking (**attach ONLY a voided check, a deposit slip is not sufficient when selecting a checking account**)

_____ Savings (**attach a deposit slip**)

Employee Name (Print) _____

Employee Signature: _____

NOTE: Any changes in Bank or Account Numbers must be made in writing and sent to:

Saint Michael's College Plan Administrator
Future Planning Associates, Inc.
600 Blair Park Road, **P.O. Box 905**
Williston, VT 05495-0905

Phone: (802) 878-6601 **FAX:** (802) 878-9455