THE MAXON COMPANY
76 NORTH BROADWAY
IRVINGTON, NEW YORK 10533

County of Dutchess Salary Reduction Cafeteria Plan
Election Form and Salary Reduction Agreement

Dependent Care Spending Account

PLEASE PRINT CLEARLY, COMPLETE ALL PERTINENT SECTIONS

EMPLOYEE INFORMATION

1. EMPLOYEE'S LAST NAME	FIRST	MI	2.PHONE-WORK	3.HOME	4. I.D NUMBER	5.COVERAGE TYPE

6. ADDRESS-STREET	CITY, STATE	ZIP	

7. EMPLOYER NAME AND LOCATION (CITY&STATE)	8.HIRE DATE	9. STATUS	
		ACTIVE ○ RETIRED ○	

10. DEPENDENTS COVERED	
SPOUSE	
CHILDREN	

PLANS ELECTING

I have reviewed the terms of the County of Dutchess Salary Reduction Cafeteria Plan. I understand that I may elect coverage under the following plan component: Dependent Care Reimbursement Account, under which I may establish a pre-tax account from which I will be reimbursed for my eligible dependent care expenses, up to an annual limit of $5,000, $2500 for married employee filing separately (prorated for first year if not a full Plan Year).

I understand that the premiums for the coverages that I elect will be deducted from my compensation on a pre-tax basis.

Please enroll me in the Dependent Care Flexible Spending Account. My election amount is $_____per payroll for ___ payrolls. Annual Total: $ _____ (Max - $5000; $2500 for married employee filing separately) Signature _____	I elect to waive Dependent Care Flexible Spending Account Benefits Signature _____

Waiver of Pre-Tax Benefits Under The Salary Reduction Cafeteria Plan

If I have waived any or all pre-tax benefits under the Salary Reduction Cafeteria Plan, I understand that except for a Change in Status, or a change in cost or coverage, as defined in the Plan, I understand that I cannot elect pre-tax benefits until the next Open Enrollment Period, and any after-tax coverages shall be outside the Plan.

Signature _____

EMPLOYER USE ONLY				MAXON USE
REASON FOR APPLICATION				
	DEPARTMENT			
	EMPLOYER SIGNATURE		DATE	

11/06