



HR USE ONLY:
 PS Entered: _____
 Audited: _____
 Confirmation: _____

**HEALTH CARE SPENDING AND DEPENDENT CARE SPENDING ACCOUNTS
 ENROLLMENT AND AGREEMENT FOR
 ENERGY NORTHWEST**

PLAN YEAR: 2006 EFFECTIVE DATE OF: 01/01/2006

Employee Name _____

Employee Number _____ SSN _____

Home Address _____

City _____ State _____ Zip _____

I understand that rules and regulations of IRC Section 125 allow an employee to redirect salary that is a payroll deduction into the following qualified benefits on a pre-tax basis. I hereby elect to participate in the employer's Health Care and/or Dependent Care Flexible Spending Accounts plan year **January 1 through December 31, 2006** as follows:

HEALTH CARE EXPENSES \$ _____ Annual
 Enter annual amount (minimum \$500.00 and maximum \$5,000.00).

DEPENDENT CARE EXPENSES \$ _____ Annual
 Enter annual amount (minimum \$500.00 and maximum \$5,000.00).

EMPLOYEE STATEMENT SIGNATURE:

I certify that I have read and understood the enrollment form and descriptive material covering the **Health Care and Dependent Care Accounts** provided.

I understand that this enrollment form will remain in effect and cannot be revoked or changed during the Plan Year, unless the revocation and new election are on account of and consistent with a change in status. Further, my election on this enrollment form revokes any prior election relating to the same matter under the Plan. My participation in the Plan terminates on the last day of the Plan Year. Before the beginning of each Plan Year, I will be offered the opportunity to change my election for the following Plan Year.

I also understand that by offering this plan, the employer has provided no tax advice to me regarding participation in this plan; therefore, I agree to hold the employer harmless for any future taxes or penalties that may be imposed by the Internal Revenue Service due to future interpretations or changes in the laws governing the flexible benefits plan or flexible spending accounts.

I authorize and direct the employer to reduce my salary in the amount necessary to pay for the benefits shown above for the Plan Year. I understand that any amounts left in my reimbursement account after all claims have been paid at the end of the Plan Year will be forfeited.

YES, I would like to participate as indicated above.

 Employee's Signature

 Date