Flexible Spending Accounts

ELECTION FORM

LSI Corporation _____ Employee Name _____

Plan Year _____ Social Security # _____

Pay Periods in Plan Year _____ Address _____

Date of Hire _____

DEPENDENT CARE REIMBURSEMENT ACCOUNT ELECTION

The Dependent Care Reimbursement Account allows you to use pre-tax dollars to pay for eligible dependent care expenses which enable you and your spouse, if applicable, to work.

Total Contribution for the remainder of current year ($5,000 annual max) $ _____ ÷

FOR PAYROLL USE ONLY

_____ = $ _____

No. of Pay Periods within Plan Year

Your Pay Period Pre-Tax Salary Reduction

HEALTH CARE EXPENSE ACCOUNT ELECTION

The Health Care Expense Account allows you to use pre-tax dollars to pay for expenses which are not 100% covered or are ineligible for payment through any group health care plan(s) under which you or your spouse are covered.

Total Contribution for the remainder of current year ($5,000 annual max) $ _____ ÷

FOR PAYROLL USE ONLY

_____ = $ _____

No. of Pay Periods within Plan Year

Your Pay Period Pre-Tax Salary Reduction

I authorize the above selections and the subsequent adjustments to my base annual salary, I am aware that I have a grace period (see "Program Highlights") in which to submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited. I understand that my elections are binding for the entire plan year and cannot be altered unless I experience a family status change.

Signature _____ Date _____

LSI HR Information Center • Mail Stop AL100 • Fax 719-533-7668

Direct Deposit Authorization for Flexible Spending Accounts

Includes Dependent and Healthcare Accounts Company: LSI Corporation

I (we) hereby authorize TRI-AD to initiate credit entries and to initiate if necessary debit entries and adjustments for any credit entries in error to my (our) checking/savings account indicated below.

SECTION I – BANK INFORMATION		
BANK NAME	BRANCH	TYPE OF ACCOUNT (CIRCLE) CHECKING SAVINGS
ADDRESS (STREET)	CITY/STATE	ZIP CODE

SECTION II - ATTACH VOIDED CHECK OR FILL IN BELOW

|__|__|__|__|__|__|__|__|__| |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Bank routing/Transit number Account Number

TRI-AD WILL PROVIDE ME WITH A NOTIFICATION OF DEPOSITOR STATEMENT which will include amount deposited to my checking/ savings account and date of the transfer deposit. This authority is to remain in full force and effect until Bank has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Bank a reasonable opportunity to act on it, or until BANK has sent me (or either of us) ten (10) days written notice of BANK'S termination of this arrangement.

SECTION III – EMPLOYEE INFORMATION	
YOUR FULL NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY # / /
DAY TIME PHONE	HOME PHONE

SECTION IV – SIGNATURE	
EMPLOYEE SIGNATURE	DATE

SECTION V – OTHER SIGNATURE (IF JOINT ACCOUNT)	
SPOUSE SIGNATURE	DATE

Please mail or fax this completed form and voided check (if applicable) to:

TRI-AD
FSA Administration Unit
221 W. Crest Street, Suite 300
Escondido, CA 92025