

ENROLLMENT FORM

ELECTION AND COMPENSATION REDUCTION AGREEMENT

Company Name: _____

Plan Year: _____

Employee Name: _____

Employee Social Security Number: _____

Employee Address: _____

Employee Email Address: _____

In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected for the plan year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts set forth below for each pay period and plan year (or during such portion of the year as remains after the date of this agreement).

ELECTION OF MEDICAL REIMBURSEMENTS

I elect to receive medical reimbursements for the plan year.

Salary Redirection: The amount of per pay compensation redirection will be \$_____. The annual election is \$_____ (per pay election multiplied by number of pays left in the Plan Year - **do not round up or down**).

NOTE: The annual plan limit which may be allocated to the medical reimbursement account is \$_____.

I understand that:

-- Reimbursements will be available only for "qualifying medical care expenses." Generally, "qualifying medical care expenses" are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation) or otherwise allowed by law. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

-- This section of the agreement will automatically terminate if the Plan is terminated or discontinued.

-- If I cease my employment with the Employer, my participation will cease. No further contributions will be made to the Plan on my behalf, although I may be entitled to reimbursement for claims incurred prior to my date of termination.

-- I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction on my tax return.

Women's Health and Cancer Rights: This plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

ELECTION OF DEPENDENT CARE ASSISTANCE

I elect to receive dependent care assistance for the plan year.

Salary Redirection: The amount of per pay compensation redirection will be \$_____. The annual election is \$_____ (per pay election multiplied by number of pays left in the Plan Year - **do not round up or down**).

I understand that:

- Reimbursement will be available only for "qualifying dependent care expenses" as described in the Internal Revenue Code Section 129, the plan document, and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- I agree to provide the Administrator with proof from the service provider that includes the amount of the expense and the date(s) that the expense has been incurred. I will also provide the Administrator with the name, address, and if applicable, the taxpayer identification number of the service provider.
- This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year.
- I will only be reimbursed for amounts up to the balance in my account at the time of my request.
- I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

OTHER TERMS AND CONDITIONS

I understand that:

- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the plan year unless I have a change in status and my election is consistent with such change.
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.
- Any amounts that are not used during a plan year plus grace period (if so specified in the Plan and Summary Plan Description) to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later plan year.
- If I select to be covered under the disability insurance through the Plan, then any benefits paid to me from such insurance will be fully taxable to me and that it will be my responsibility to include these amounts in my gross income.
- My social security benefits may be slightly reduced as a result of my election.
- Prior to the first day of each plan year, I will be offered the opportunity to change my benefit elections for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit coverage and amount of compensation reduction then in effect for the new plan year for insurance benefits only. For all other benefits, I will be deemed not to have elected any other benefits for this plan year.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN.

Employee's signature

Date

Accepted and agreed to by the Employer's Authorized Representative-

Authorized Representative signature

Date

FOR MID-YEAR ENTRY ONLY:

Authorized Representative, please complete the following if an employee joins the plan any time other than prior to the start of the plan year.

Employee's Entry Date: _____

First Pay Deduction will begin with the Payroll of: _____