HEALTH INSURANCE OPT-OUT FORM

ELECTION AND COMPENSATION REDUCTION AGREEMENT

Company Name: _____

Employee Name: _____

Employee Social Security Number: _____

Employee Address: _____

Employee Email Address: _____

Plan Year: _____

In accordance with my rights under the Plan, I elect to allocate from the Employer's Contribution the full amount as a cash benefit. I understand that this allocation will become a taxable benefit to me.

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.

-- 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