

FLEXIBLE SPENDING PLAN BENEFIT ELECTION AND COMPENSATION REDUCTION

NAME _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____

_____ I elect to contribute to **HEALTH CARE ACCOUNT** \$ _____ **ANNUAL AMOUNT**

_____ I elect to contribute to **DEPENDENT CARE ACCOUNT** \$ _____ **ANNUAL AMOUNT**

_____ I do not wish to contribute to the Flex Spending Health Care or Dependent Care at this time.

Flexible Spending Plan. Any previous election and compensation reduction agreement under the Flexible Spending Plan relating to the same benefits is hereby revoked.

I agree that my regular pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected above, effective _____ (date) and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution for each benefit option selected is set forth on a schedule that has been provided to me.

I understand that in accordance with IRS regulations and this plan: *(please initial each statement)*

_____ I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to next January 1, unless that change or revocation is on account of and consistent with a change in my family status [i.e, my marriage or divorce, death of my spouse or dependent, birth or adoption of my child, significant change in my or my spouse's employment status, a significant change in my or my spouse's health coverage attributable to my spouse's employment, and such other events as the Plan Administrator determines will permit a change or revocation of an election.]

_____ I will be reimbursed for eligible expenses from the appropriate account. As required by IRS regulations any funds not used for reimbursement of eligible expenses cannot be returned to me.

_____ Prior to January 1 each year, I will be offered the opportunity to change my benefit coverage(s) for the following Plan Year (January 1 to December 31). If I do not complete and return a new election form at that time with respect to the coverages listed above, I will be treated as having elected to continue for the new Plan Year those coverages listed above that are in effect for me just prior to the new Plan Year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for those coverages.

_____ The Plan Administrator may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the Flexible Spending Plan, if the Administrator believes it advisable in order to satisfy certain provisions of the Internal Revenue Code. In addition, adjustments may be made in my pay reduction (or new election may be permitted), to the extent provided in the Flexible Spending Plan, in the event of an increase or decrease in the cost of dental or medical care coverage provided by an independent third party provider.

_____ The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans.

Employee Signature _____

Date _____