Flex Benefits Plan
Health and Dependent Care Enrollment Form

Employer: _____

Social Security _____ **E-mail:** _____

Last _____ **First** _____

Address _____

City: _____ **State:** _____ **Zip:** _____

New Plan Year Enrollment

Change in Plan Year Enrollment

Effective Date: _____

Date of Change: _____

Description of Change: _____

_____

Employer will start Payroll Deductions on this Pay Date: _____

I elect to participate in the:

For the following pre-tax amounts:

Dependent Care Reimbursement Account $ _____ per pay period

Health Care Reimbursement Account $ _____ per pay period

My signature below certifies that I authorize my employer to make the appropriate payroll deductions to cover the above elections. I have read, understand and agree to all of the information on the reverse side of this enrollment form.

Signature: _____ **Date:** _____

For Employer's use only:

Confirm effective date (following signature date) _____

Per Pay Period Deduction Amount $ _____

Authorization: _____

Flexible Benefits Plan Enrollment Form -- Side 2

Important Information

The employer indicated on the reverse side and I hereby agree that my salary will be reduced by the amounts indicated on this form (in equal increments each pay period), beginning the first pay date following the effective date (or on the pay date indicated) and continuing for every successive pay period during this Plan Year until this Agreement is amended or terminated.

I understand that I cannot change or revoke my election in the Dependent Care Reimbursement Account prior to the start of the next Plan Year **unless** I have experienced a change in family status (as defined by the IRS) within the past 60 days **and** my new election is consistent with that change. The following are examples of a change in my family status: 1) marriage, divorce or legal separation, 2) death of my spouse or dependent, 3) birth or adoption of my child, 4) commencement or termination of my spouse's employment, 5) switching from part-time to full-time or from full-time to part-time employment status by me or my spouse, 6) taking of or returning from an unpaid leave of absence, and 7) significant change in my health coverage or the health coverage of my spouse attributable to my spouse's employment.

I understand that I cannot change or revoke my election in the Health Care Reimbursement Account and/or Premium Contribution Plan prior to the start of the next Plan Year **unless** I have experienced a change in status (as defined by the IRS) within the past 60 days **and** my new election is consistent with that change. The following events are changes in my status: 1) change in my legal marital status - marriage, death of my spouse, divorce, legal separation or annulment, 2) change in the number of my tax dependents - birth, adoption, placement for adoption or death of a dependent, 3) termination or commencement of my employment or the employment of my spouse or dependent, 4) change in my work schedule or the work schedule of my spouse or dependent - switch between part-time and full-time status, a strike or lockout, taking of or returning from an unpaid leave of absence, 5) my dependent satisfies or ceases to satisfy dependent eligibility requirements for my health coverage, 6) change in my place of residence or worksite, or change in the residence or worksite of my spouse or dependent, 7) I, my spouse or dependent have a right to enroll for coverage due to the Health Insurance Portability and Accountability Act (HIPAA), 8) I, my spouse or dependent become entitled to Medicare or Medicaid, and 9) significant change in my health coverage or the health coverage of my spouse attributable to my spouse's employment.

If my required premium contributions for the elected employer-sponsored insurance benefits should increase or decrease during the Plan Year, the premium contributions noted on the reverse side of this form will be automatically adjusted accordingly by my employer.

If my employer is required by law to comply with COBRA regulations, I understand that (under COBRA guidelines), if my employment is terminated, I am eligible to participate in the Health Care Reimbursement Account on a COBRA basis.

I will be offered the opportunity to change my election prior to the start of the following Plan Year. To re-enroll, I must complete a new election form. If I do not complete and return a new election form at that time, I will be treated as having elected to discontinue participation in the Plan.

I understand that I am required to properly complete a reimbursement claim form and provide adequate proof of having incurred each expense in order to obtain reimbursement. The Contract Plan Administrator reserves the right to deny any claim if the documentation is incomplete or if the expense is not eligible as allowed by the Plan.

I understand that I have up to ninety (90) days from the end of the Plan Year, or the date I cease to be a participant in the Plan (due to termination or qualified change) whichever is earlier, to claim any unused balance in my reimbursement account(s). To be eligible for reimbursement, the expenses must be incurred during the Plan Year, or during the time I was a participant in the Plan. All unused funds at the end of the ninety (90) day period will be forfeited.

I understand that I am responsible for any tax consequences which may result from the reimbursement of expenses from this Plan. I also understand that any expenses reimbursed from this Plan may not be claimed on my or my spouse's State or Federal tax return for the purposes of tax reduction (credit or deduction).

The Plan Administrator may reduce or cancel this Agreement if it is advisable in order to satisfy provisions of the Internal Revenue Code.

My signature on the reverse side of this form certifies that I have examined this Agreement in full and, to the best of my knowledge and belief, it is true, correct and complete.