

Employer Name: _____

FSA Salary Redirection Agreement

Division: _____ Plan Year _____

Name: _____ Social Security No.: _____ Birthdate: _____

Address: _____

Eligibility Date: _____ Date of First deduction: _____

Status Change: _____ Effective Date: _____

I authorize my employer to deduct on a pre-tax basis for the applicable plans below for which I am participating:
Complete the following elections if participating in a Medical or Dependent Care FSA Plan:

Medical FSA: \$ _____ per pay period X _____ no. of deductions = \$ _____ annual election

Dependent Care FSA: \$ _____ per pay period X _____ no. of deductions = \$ _____ annual election
(\$5,000 maximum for married couple and \$2,500 maximum for single parent)

Transportation Benefit: \$ _____ per pay period X _____ no. of deductions = \$ _____ annual election
(\$230 maximum for parking and \$120 maximum for mass transit)

Flex Premium: \$ _____ per pay period X _____ no. of deductions = \$ _____ annual election
(Family portion of Group Medical and qualified Voluntary Products)

I understand and agree that by electing any of the above that (initial all):

Initial

On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement **with respect to pre-tax premiums before the next anniversary date of the plan** unless a "change in family status" occurs (as defined under the Plan and Internal Revenue Code), and the change is caused by and consistent with the "change in status." **I understand that I cannot revoke any pre-tax election based on a Right to Examine provision as may be contained in any insurance plan or policy issued to me.**

Initial

Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or insurance policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue. Elections under the Medical and Dependent Care FSA plans will not continue without my completing and submitting a new Salary Redirection Agreement prior to the beginning of each plan year.

Initial

FOR MEDICAL AND DEPENDENT CARE FSA PARTICIPANTS: I verify that I have received a summary of the tax rules, operational guidelines and reimbursement procedures for use in Medical and Dependent Care FSA plans. I understand the plan document will control notwithstanding any contrary oral representation by any person. I understand that reimbursement will be available only for eligible expenses, and I agree to notify my employer if I receive reimbursement for an expense that does not qualify. I also agree, upon demand, to indemnify and reimburse my employer for any liability it may incur for failure to withhold taxes from any reimbursement I receive for non-qualified expenses, up to the amount of additional tax owed by me. Furthermore, I understand that any account surplus at the end of the plan year shall be retained by my employer and such amounts may (but are not required to) be used to offset administrative expenses or future costs, and that the obligation to make reimbursements is the responsibility of my employer and not any service provider hired by my employer to assist in processing claims. I understand that I may be responsible for a monthly service fee for Medical and Dependent Care FSA plans and authorize my employer to payroll deduct any required service fee amount. I acknowledge that in some cases reimbursement for eligible Medical and Dependent Care FSA expenses may be administered through an electronic payment card ("the Card") and agree to abide by the terms and conditions of the Plan with regard to such card usage and the electronic payment cardholder agreement, including any fees applicable to the Card, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. I also agree to use the Card exclusively for Medical and/or Dependent care FSA expenses and to retain paper documentation for any claims adjudicated by the Card.

WAIVER OF PRE-TAX BENEFIT UNDER THE FLEXIBLE BENEFITS PLAN

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. I elect to waive all pre-tax benefits under the plan, and understand that the benefits may be elected on an after-tax basis. Except for a change in family status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

Initial

Signature _____

Date _____