Cafeteria Plan Election Form and Compensation Reduction Agreement

Company Name: ____

Employee Name: ______________________________ Social Security Number: ______________

Employee Address: ______________________________ City,ST,Zip ______________

Employee Email: __________________ Plan Year __________ Effective Date: __________

Election and Compensation Reduction Agreement for Coverage under Certain Benefit Plans

I elect to receive the following coverage under the Cafeteria Plan (pre-tax deduction): **_____I have declined Company Benefits**

1

Coverage For:	Myself	Spouse	Children	Premium per
Health Insurance Coverage	________	________	________	________
Dental Coverage	________	________	________	________
Disability Coverage	________	________	________	________
______________	________	________	________	________

2

I elect to receive PRIVATE INDIVIDUAL HEALTH REIMBURSEMENTS for the plan year. _____Check to decline

Amount of compensation reduction: $_______*per each pay period, which is a total of $_________ for the plan year. The annual plan limit is __________ per participant for this plan year.

**Election ÷ # pay periods=per pay deduction.*

I understand that:

___ If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect that increase or decrease.

___ Prior to the first day of each plan year, I will be offered the opportunity to change my election for the following plan year. If I do not complete and return an election form at that time, I will be treated as having elected to continue my benefit coverage then in effect for the new plan year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for the benefit option.

I elect to receive MEDICAL REIMBURSEMENTS for the plan year. _____Check to decline

3

Amount of compensation reduction: $_______*per each pay period, which is a total of $_________ for the plan year. The annual plan limit is _________ per participant for this plan year.

**Election ÷ # pay periods=per pay deduction*

I understand that:

___ Reimbursements will be available only for "qualifying medical care expenses." I agree to notify the company 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 company on demand for any liability it may occur for failure to withhold federal, state, or local income tax or social security tax from any reimbursement I receive of a nonqualfiying expense, up to the additional amount of tax actually owed by me.

I elect to receive DEPENDENT CARE REIMBURSEMENTS for the plan year. _____Check to decline

4

Amount of compensation reduction: $_______* per each pay period, which is a total of $_________ for the plan year. The annual plan limit is __________ per participant for this plan year.

**Election ÷ # pay periods=per pay deduction.*

I understand that:

___ Reimbursement will be available only for "qualifying dependent care expenses."

___ I agree to provide the Plan Administrator with the name, address, and the tax payer identification number of the service provider. I am responsible for providing this information on Form 2441 of my federal income tax return.

THE AGREEMENT IS SUBJECT TO THE TERMS OF THE COMPANY'S CAFETERIA PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S). I CANNOT CHANGE OR REVOKE THIS COMPENSATION REDUCATION AGREEMENT AT ANY TIME DURING THE PLAN YEAR UNLESS I HAVE A QUALIFYING CHANGE OF STATUS.

Employee Signature______________________________ **Date**____________________

Accepted By ______________________________ **Date**____________________