

**ELECTION AGREEMENT - Plan Year 01/01/10 – 12/31/10**

I, the undersigned employee of \_\_\_\_\_ hereby make the following election regarding the benefits available to me under the Section 125 Flexible Benefit Plan. I am further making an election to have my taxable compensation reduced by an amount equal to the value of the benefits specified below, such amount to be deducted in approximately equal sums from my regular paychecks during the coming Plan Year. I understand this contribution is to be paid with pre-tax dollars. This election form cannot be revoked or changed during the plan year, unless there is a life status change. I understand that salary reductions must be reimbursed for qualified expenses incurred during the plan year and may not be carried over into future plan years. If at the end of the plan year, my total contributions exceed my qualified expenses, the difference in amounts will be forfeited per IRS Code.

1. Dependent Care Expenses \$ \_\_\_\_\_ /Annual \$ \_\_\_\_\_ /Per Pay Period. Initials: \_\_\_\_\_

**Single/ Married (filing joint tax return) Maximum Deferral - \$5,000 annual**

**Married (filing separately) Maximum Deferral - \$2,500 annual**

2. Medical Reimbursement Plan \$ \_\_\_\_\_ /Annual \$ \_\_\_\_\_ /Per Pay Period. Initials: \_\_\_\_\_

**Annual Maximum Deferral \$**

\_\_\_\_\_  
Employee's Last Name                      First                                      MI                                      Telephone #

\_\_\_\_\_  
Employee's Address                      Street                                      City                                      State                                      Zip

\_\_\_\_\_  
Email Address                                      Date of Birth                                      Date of Hire

Select One:

I elect to have my reimbursements deposited into my bank account (authorization for automatic reimbursement form attached).

I elect to have my reimbursements mailed to the address provided above.

	Dependent Information	Sex	Date of Birth
Spouse			
Child			
Child			
Child			

**Signature** \_\_\_\_\_ **Social Security** \_\_\_\_\_ **Date** \_\_\_\_\_

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**Waiver of Participation**

I acknowledge that I have been given the opportunity to participate in the Section 125 Flexible Benefit Plan, sponsored by my Employer and choose not to participate in the Plan at this time. By waiving participation in the Flexible Benefit Plan this year, I realize that I will not again become eligible to participate until the next Plan Year.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_