ELECTION AND SALARY REDUCTION AGREEMENT

(PLEASE PRINT)

EMPLOYER: _____

PLAN YEAR: _____ **thru** _____

ELIGIBILITY DATE:_____ **FIRST PAY DATE:** _____

PAY MODE (M-Monthly, S-Semi Monthly, Bi-Biweekly or W-Weekly): _____

LOCATION NAME & NO.: _____

NAME:_____ **SSN:** _____

ADDRESS:_____ **DOB:** _____

_____ **DOH:** _____

_____ **SALARY (Per Pay Period): $** _____

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary necessary to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform with a cafeteria plan in accordance with Sections 125, 79, 105, 106 and 126 of the Internal Revenue Code.

INSURANCE ELECTIONS:	**CAFETERIA** (Per Deduction)	**NON CAFETERIA** (Per Deduction)	**Deduction Mode**
PRE-TAXED			
_____	_____		_____
_____	_____		_____
_____	_____		
_____	_____		
_____	_____		
POST TAXED			
_____		_____	_____
_____		_____	
_____		_____	

M - Monthly = 12
S - Semi Monthly = 24
Bi - Bi Weekly = 26
W - Weekly = 52

FLEXIBLE SPENDING:	**AMOUNT** (Per Deduction)	**PLAN YEAR AMOUNT**
Dependent Care Expenses:	_____	
Unreimbursed Medical Expenses:	_____	
Premium Reimbursement:	_____	

Please sign only one line.

YES I **WISH TO PARTICIPATE -** I agree that my salary will be reduced by the amount(s)shown for the benefit option(s) I have elected under the Cafeteria Plan. I have read and understand the information on the reverse side of this document.

EMPLOYEE SIGNATURE: _____ DATE: _____

NO I **DO NOT WISH to Participate** - I have been explained the benefits of the Cafeteria Plan and given the opportunity to participate, but I DECLINE. I understand that I may only participate at the start of the next Plan Year or in the event of a Status Change.

EMPLOYEE SIGNATURE: _____ DATE: _____

Southern Administrators and Benefit Consultants, Inc.
P.O. Box 2449 ⊂ Madison, Mississippi 39130-2449
WWW.SABCFLEX.COM

As a participant, I understand the following:

My salary will be reduced by the amount shown on the reverse side of this page for the benefit option(s) I have elected under the Cafeteria Plan.

- C My social security benefits may be reduced due to my participation in the Cafeteria Plan.

- C Elections made will be irrevocable for the plan year except for modifications due to a qualified Change in Status (divorce, marriage, death of spouse or dependent, birth or adoption of a child, or the change of employment status of a spouse).

- C If my salary reduction for the elected insurance benefit(s) are increased or decreased while this agreement remains in effect, my salary will automatically be adjusted to reflect the change.

- C Prior to each plan year, I will be given the opportunity to change my benefit election. If I fail to complete and return a new election form within the regular enrollment period, preceding each plan year, I understand my election will remain the same.

- C My employer may reduce or cancel the amount of my salary reduction or otherwise modify this agreement in order to satisfy certain provisions of the Internal Revenue Code.

- C If I participate for dependent care expenses, I will be reimbursed up to the amount incurred during the plan year, not to exceed the amount of my dependent care balance.

- C If I participate for the Unreimbursed Medical (URM) expenses, I will be reimbursed for out-of-pocket medical expenses up to the amount incurred (date service was provided, not paid) during the plan year, not to exceed my plan year election.

- C If I participate for the Dependent Care and/or Unreimbursed medical expense spending account(s), any funds remaining after the end of the sixty (60) days grace period, following the end of the plan year, will be forfeited to my employer.

- C I have been explained the flexible spending reimbursement procedures and the requirements of the plan, I understand my reimbursements will be based on certain required third party documentation and eligibility of the expense. I understand that upon submission of each claim, I certify that the documentation submitted is valid and eligible under the guidelines of the plan. Submission of falsified and/or inaccurate information may result in disciplinary action and/or penalties.

TERMINATION OF EMPLOYMENT:

Please refer to your plans Summary Plan Description or contact your Plan Administrator and/or SABC for the following plan design information:

I understand that if I terminate my employment, my elected benefits under the Cafeteria Plan will cease. Depending on my Employer's Plan design, my Unreimbursed Medical election may:

- C Continue, in lieu of COBRA, my Employer will deduct from my salary (pre-taxed) any unpaid URM elections for the plan year.

- C Terminate, and I will only be able to claim for expenses that incurred prior to my termination. If I have a positive URM balance at the time of termination, I can extend my election due to a COBRA qualifying event and I will be given the opportunity to continue on a self pay basis.

PREMIUM REIMBURSEMENT PLANS:

- Premium Reimbursement Account participants must submit a declaration of coverage from their provider which indicates the policy is in effect. After each payment that corresponds with the payments due for months included in the plan year, participant must submit, along with a Request for Reimbursement form and proof of payment.

- C The maximum amount of reimbursement for Premium Reimbursement Accounts is based on the yearly cost of individually contracted health premiums.

MY ELECTION AND SALARY REDUCTION AGREEMENT IS SUBJECT TO THE TERMS OF MY EMPLOYER'S CAFETERIA PLAN DOCUMENT.