

FLEXIBLE BENEFIT PLAN (Health Care/Dependent Care)

ELECTION / CHANGE FORM

Name: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Home: _____ Telephone Work: _____

New Change Change Reason _____

INSURANCE PREMIUM CONVERSION:

If you pay by payroll deduction, your share of qualified premiums will automatically be tax-free. No election is necessary to receive this benefit.

HEALTH CARE REIMBURSEMENT ACCOUNT:

If you choose to participate in the Health Care Reimbursement Account, use the information from the worksheet in your booklet to determine the amount you want to redirect during the plan year. Divide this amount by the number of paychecks you will receive during the plan year to determine the amount to be redirected each payday.

YEARLY AMOUNT	NO. OF PAYDAYS DURING THE PLAN YEAR	AMOUNT EACH PAYDAY

DEPENDENT CARE REIMBURSEMENT ACCOUNT:

If you choose to participate in the Dependent Care Reimbursement Account for work-related day care expenses, use the information from the worksheet in your booklet to determine the amount you want to redirect during the the plan year. Divide this amount by the number of paychecks you will receive during the plan year to calculate the amount to be redirected each payday. The calendar year maximum is the smallest of you or your spouse's taxable income, \$5,000.00 or \$2,500.00 if you are married and you and your spouse file separate income tax returns.

YEARLY AMOUNT	NO. OF PAYDAYS DURING THE PLAN YEAR	AMOUNT EACH PAYDAY

SIGNATURE: *By signing this form, I authorize my employer to redirect (reduce) me taxable pay by the amounts. I understand and agree that:*

- (1) I cannot change or suspend my election until the next plan year unless my family status changes.
- (2) I cannot transfer money between the reimbursement accounts.
- (3) Any money in my accounts not used to pay qualified expenses incurred during the plan year will be forfeited.
- (4) The redirections I have elected are made in accordance with the plan document and the provisions of IRS Code Section 125, and will be deducted from my paycheck in equal installments throughout the plan year.

Signature

Date

Please submit this form to your employer before the plan effective date, within 30 days of employment, or within 30 days of a change in family status. You may make a photocopy of this form for your records. Questions regarding the administration of your reimbursement accounts, if elected, should be directed to FlexBen Corporation @ (800)433-4169