AMERICAN BENEFITS GROUP

FLEXIBLE SPENDING ACCOUNTS - ELECTION FORM

You must complete and return this form. Please print.

Name: _____ Social Security #: _____

Home Address: _____ Email: _____

City, State, Zip: _____ Phone: _____

Employer: _____ Division: _____

Date of Birth: _____

I hereby authorize my employer to reduce my salary (on a pre-tax basis) by the amount necessary to pay for the coverages indicated below. I understand that I must use all my flexible Benefit contributions or forfeit them.

Health Flexible Spending Account (FSA):
(Maximum Annual Election is $3,050) ☐ Yes ☐ No $ _____ ANNUAL AMOUNT

Dependent Care Assistance Plan (DCAP):
(Maximum Annual Election is $5,000) ☐ Yes ☐ No $ _____ ANNUAL AMOUNT

I understand that by choosing the limited purpose FSA I can only use this benefit to be reimbursed for vision and dental expenses and that participation in this benefit will not preclude me or my family members from making contributions to our Health Savings Account.

Please complete the following dependent information and indicate if requesting a debit card:

Last Name _____ First Name _____ Date of Birth _____
Dependent SS#: _____ Relationship: ☐ Spouse ☐ Dependent Card: ☐ Yes ☐ No

Last Name _____ First Name _____ Date of Birth _____
Dependent SS#:_____ Relationship: ☐ Dependent Card: ☐ Yes ☐ No

Last Name _____ First Name _____ Date of Birth _____
Dependent SS#: _____ Relationship: ☐ Dependent Card: ☐ Yes ☐ No

Your election to participate in any pre-tax eligible benefits will constitute an election under your employers Section 125 Cafeteria Plan and any contributions you are required to make under any such plan will be deducted from your (examples: Group Health, Dental and Vision Plan) salary on a pre-tax basis unless you requested otherwise.

_____ _____ _____ _____
Employee Signature Date Employer Authorization Date

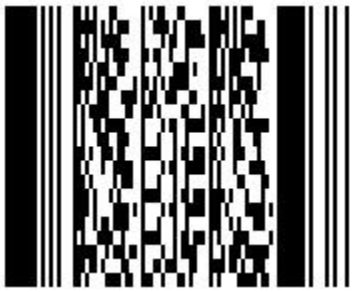
EMPLOYER – PLEASE COMPLETE

Benefit Effective Date _____

Pay Date for 1st Contribution _____ Number of Pay Periods _____

Fax: 877-723-0147 or email: processing@amben.com

Mail: American Benefits Group • PO Box 1209, Northampton, MA 01061-1209 • 800-499-3539



In signing the reverse of this form, I understand and agree to the following:

The Company and I hereby agree that my cash compensation will be reduced by the amounts I have elected on this form on a per pay-period basis during the plan year (or during such portion of the year as remains after the date of this agreement).

THIS 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, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a status change event (including marriage, divorce, death of a spouse or child, birth or adoption of a child, change in employment status, change in job schedule of participant or spouse, dependent satisfying or ceasing to satisfy dependent eligibility requirements, entitlement to Medicare or Medicaid, judgment, decree or court order or such other events as the Plan Administrator determines will permit a change or revocation of an election).

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code. The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.

The amount of my compensation reduction during the year will be credited to an insurance, medical reimbursement, and/or dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed for qualified expenses incurred during the plan year. If I terminate employment, I will only be reimbursed for expenses incurred prior to my termination date unless I qualify for, and elect COBRA coverage.

My Social Security benefits may be slightly reduced as a result of reduced taxable income due to my election(s).

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

Health Flexible Spending Account (FSA) will be available only for “qualifying medical care expenses” which are those types of medical expenses normally deductible on your federal income tax return with certain exceptions (i.e., premiums for health insurance cannot be reimbursed from your Health FSA). I agree to notify the company if there is reason to believe that any expense for which reimbursement has been obtained is not a qualifying expense. I also agree to indemnify and reimburse the company on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.

Limited Purpose FSA (LPF) Your Limited Purpose/Post Deductible Health Flexible Spending Account can only be used to reimburse vision, dental and preventive expenses until you have incurred the federally mandated amount of deductible expenses. Once you have reached the federally mandated deductible, you may use the funds in your Limited Purpose/Post Deductible Health Flexible Spending Account to be reimbursed for General Purpose FSA medical expenses incurred after the date you reached the deductible.

Dependent Care Assistance Plan (DCAP) will be available only for “qualifying dependent care expenses” as described below. I agree to notify the company if there is 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 incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of such tax actually owed by me.

I agree to provide the Plan Administrator with the name, address, and taxpayer identification number of each dependent care service provider.

Qualifying Dependent Care Expenses:

1. The expenses are incurred for services rendered after the date of this election and during the plan-year to which it applies.
2. Each individual for whom you incur the expenses is (a) a dependent under the age 13 whom you are entitled to claim as a dependent* on your federal income tax return or (b) a spouse or other tax dependent* who is physically or mentally incapable of caring for himself or herself.

   *or a child or other dependent under age 13 whom you are supporting but are not entitled to claim as a dependent only because of a written declaration or decree of divorce.
3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.
4. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 2(a) above, or who regularly spends at least 8 hours a day in your household.
5. The expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the Facility), which complies with all applicable state and local laws and regulations.
6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.
7. The expenses are not paid or payable to an individual for whom you or your spouse are entitled to a personal tax exemption.
8. The reimbursement (when aggregated with all other reimbursements received by you under the Plan during the same year) may not exceed the least of the following limits: (a) The maximum allowed under the Plan. (b) $5,000 if you are filing a joint tax return or $2,500 if separate returns are filed. (c) Your taxable compensation (after all compensation reduction elections). (d) If you are married, your spouse’s actual or deemed earned income.

This agreement will automatically terminate if the Plan is terminated or discontinued.