SALARY REDIRECTION AGREEMENT

(Check One) ☐ Open Enrollment Or ☐ Newly Eligible Employee, Eligibility Date: ___/___/___

Social Security No: _____ Date of Birth: ___/___/___ Phone: (_____) _____
Name: (Last) _____(First) _____ (MI) _____
Street Address: _____
City: _____ State: _____ Zip: _____

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution and/or Flexible Spending Account(s) (FSA) election amounts will be deducted from my paycheck by my employer or Third Party Payroll Administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage and/or FSA account election amount as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to "employer-provided" non-elective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Flexible Benefits Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

Check the desired coverage(s) below.

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage	_____		Accident Insurance	_____	
Dental Coverage	_____		Short-Term Disability		_____
Vision Coverage	_____		Cancer Insurance	_____	
Group Term Life Insurance		_____	Hospital Advantage		_____

Complete the following section only if participating in a Medical or Dependent Care Reimbursement Plan:

Medical Care FSA Plan: ($_____ per pay period) X (____ number of deductions) = $_____Annual Election

Limited Purpose FSA Plan: ($_____ per pay period) X (____ number of deductions) = $_____Annual Election

Dependent Care DCA Plan: ($_____ per pay period) X (____ number of deductions) = $_____Annual Election

Required acknowledgement to participate in Pre-Tax Benefits plans:

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Flexible Benefits Plan. **Initial**

Waiver of Pre-Tax Benefits under the Flexible Benefits Plan:

I elect to waive all pre-tax benefits under the Flexible Benefits Plan. Except of a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after tax coverage shall be outside the plan. **Initial**

Please acknowledge the contents of this form by signing below.

EMPLOYEE SIGNATURE:_____ DATE: _____