SECTION 125 PLAN

2017 ELECTION FORM AND SALARY REDIRECTION AGREEMENT

Employee Name: _____ SSN: (last 4 digits only)_____

Plan Year: _____ through _____

As an eligible employee in the above plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected for the plan year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts set forth below for each plan year (or such portion of the year as remains after the date of this agreement). Please check appropriate box(es).

☐ **ELECTION OF DEPENDENT CARE ASSISTANCE**

I elect to receive dependent care assistance for the plan year.

The amount of compensation redirection will be $ _____for the plan year.

I understand that: Reimbursement will be available only for "Qualifying dependent care expenses: as described in the Internal Revenue Code Section 129, the plan document and the Summary Plan Description. I agree to notify the Employer if I have 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 Employer 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 non-qualifying expense, up to the amount of additional tax actually owed by me.

I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred.

I agree to provide the Administrator with the name, address, and if applicable, the taxpayer identification number of the service provider.

I will only be reimbursed for amount up to the balance in my account at the time of my request.

I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

This section of the agreement will automatically terminate if my employment terminates or the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan year.

☐ ELECTION OF LIMITED PURPOSE HEALTH REIMBURSEMENTS

I elect to receive limited purpose health reimbursements. The amount of salary redirection will be $ _____ for the plan year. Maximum contribution amount is $2,600.

I understand that: Reimbursements will be available for limited purpose health reimbursements only. Limited purpose health reimbursements are for dental, vision, preventive care and post-deductible expenses only. I agree to notify the Employer if I have 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 Employer 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 additional tax actually owed by me.

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

If I cease my employment with the Employer, my participation in the Plan will cease. Unless I elect COBRA continuation coverage, NO further contributions will be made to the Plan on my behalf, although I may be entitled to reimbursements for claims incurred prior to my date of termination.

I cannot seek reimbursement from this account for an expense which I intend on taking as a deduction on my tax return or which has been covered by insurance.

☐ OTHER TERMS AND CONDITIONS

I understand that: I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in spouses' employer-sponsored health coverage, or such other events the Plan Administrator determines will permit a change or revocation of an election).

The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

Any amounts that are not used during a plan year to provide benefits, with the exception of the Limited Purpose Health FSA unused amounts up to $500, will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later plan year.

Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue the pre-tax premium payment for the group insurance coverage I have elected for the new plan year, but I can not participate in the medical reimbursement or dependent care programs for the new plan year unless I experience a change in family status event.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S SECTION 125 PLAN, AS AMENDED FROM TIME TO TIME, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND SALARY REDIRECTION AGREEMENT RELATING TO SUCH PLAN.

Employee's signature: _____ Date: _____