FLEX BENEFITS PLAN

H R Support & Consulting Services, Inc.

Flex Administration
159 Watkins Shores Road
Casco, ME 04015
1 866-655-5397

REIMBURSEMENT ACCOUNT BENEFIT ELECTION FORM

☐ I elect to participate in my employer's Reimbursement Account(s) program. I agree to contribute the following amount(s) to fund my Account(s):

$ _____ per pay period for my Medical Expense Reimbursement Account ($1,200.00 annual maximum)

$ _____ per pay period for my Dependent Care Reimbursement Account ($5000. annual maximum, no minimum)

In addition to my per pay period election for Medical and/or Dependent Care Account I further understand that I will pay the yearly administration fee ($2.05 per pay period): (Check appropriate box)

__ $53.30 per yr. – 1 account **___ $106.60 per yr. – 2 accounts**

☐The benefits of the plan have been explained to me and I decline to participate.

I understand that my salary will be reduced by my contribution amount(s), taken from my paycheck in equal amounts each pay period, allowing me to fund my account(s) with pre-tax dollars. I understand that, as my contributions are free of Federal, State, and Social Security taxes (if applicable), subsequent Social Security benefits may be slightly reduced.

I understand that:

- this agreement cannot be changed or discontinued during the Plan Year unless my family status or my employment status changes;
- only medical and/or dependent care expenses allowed by the IRS and my employers plan qualify for reimbursement;
- dependent care expenses reimbursed via this plan offset dollar for dollar any child care tax credit;
- funds in my Account(s) must be used before the end of the Plan Year or be forfeited;
- the Plan Year is the period of time beginning September 1, 2009 and ending on

August 31, 2010; and

- **if I have or participate in a Health Savings Account (HSA) I am not eligible to participate in the Medical Reimbursement Account.**

I have received a written description of the Reimbursement Account program. I have read and understand the above agreement.

Employee Signature_____
Date_____

Your name *(please print)*_____

Employer_____Social Security No.___/___/____

Date of Hire____/____/_____ Birth Date____/____/_____

Address_____

City _____State_____Zip_____

When completed, send this form to Karen Thames in Payroll.