

Flexible Employees' Benefits Plan Enrollment Form (Health Care and Dependent Care Reimbursement Accounts)

Return completed form to: Flexible Employees' Benefits Plan, PO Box 304900, Montgomery AL 36130-4900
Telephone: 334.263.8324 Toll-free: 1.866.833.3378 Fax: 334.263.8512

| EMPLOYEE INFORMATION | | |
|---|-------------------|---------------------|
| Do you plan to retire in 2010? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided | | |
| Name: | Contract # | |
| Address: | | |
| City, State and Zip: | | |
| Telephone Numbers (work number is required) | | |
| Work: () | Ext: | Home: () |
| Email Address: | | |
| Did a Health Insurance Advisor speak with you about enrolling these plans? If so, please indicate which advisor. | | |
| <input type="checkbox"/> Marsha Abbett <input type="checkbox"/> Tonya Campbell <input type="checkbox"/> Kerry Schlenker <input type="checkbox"/> Rick Wages <input type="checkbox"/> Connie Wood | | |
| Health Care Reimbursement Account – for uninsured medical/dental/vision/over-the-counter and prescription expenses and deductibles, for you and your dependents but not for health insurance premiums. (Minimum annual contribution is \$120 and the maximum is \$7,500) | | |
| <input type="checkbox"/> To enroll, enter the estimated annual amount you expect to spend for qualifying out-of-pocket healthcare expenses during the plan year (January 1 thru December 31) | | |
| <input type="checkbox"/> This annual amount will be divided by the number of pay periods you will be working during the plan year. If you are employed the full year, the annual amount will be divided by 24 pay periods and taken out of each paycheck in equal amounts. | | |
| <input type="checkbox"/> To receive a Flex Spending Card or to continue to use your current card please indicate by placing a check in the box. | | |
| HCRA Annual Contribution Amount: _____ | | |
| I choose: the Flex Spending Card <input type="checkbox"/> Traditional Reimbursement (bump) <input type="checkbox"/> Manual <input type="checkbox"/> | | |
| Dependent Care Reimbursement Account – for dependent/child care related expenses, but not for dependent's medical/dental expenses. | | |
| <input type="checkbox"/> To enroll, enter the estimated annual amount you expect to spend for qualifying dependent care expenses during the plan year. (\$5,000 maximum) | | |
| <input type="checkbox"/> This annual amount will be divided by the number of pay periods you will be working during the plan year (January 1 thru December 31). If you are employed the full year, the annual amount will be divided by 24 pay periods and taken out of each paycheck in equal amounts. | | |
| DCRA Annual Contribution Amount: _____ | | |

Important – Read Carefully Before Signing

I understand that I cannot change or revoke any of my elections on this compensation redirection agreement at any time during the plan year (Jan. 1-Dec. 31) unless I have a change in status as defined by the IRS. During the annual Open Enrollment Period, I will be given the opportunity to enroll in the plan for the upcoming plan year (Jan. 1-Dec. 31). I must enroll each year during the Open Enrollment Period since participation in the plan for subsequent years is not automatic, even if I want to contribute the same amount as the previous year. **Any money left in the HCRA as of December 31 will "carry over" to the next plan year, however these funds must be used by March 15th of the new plan year or I will forfeit the amount in accordance with current plan provisions and tax laws.** I hereby certify that I have completely read and fully understand the terms and conditions of the Flexible Employees' Benefits Plan and all information furnished is true and complete.

Employee Signature: _____

Date: _____