GROUP ADMINISTRATORS, LTD.
FLEXIBLE SPENDING ACCOUNT
BENEFIT ELECTION & SALARY REDIRECTION AGREEMENT FORM

Employer Name:____

Employee Name:______________________________ Employee SSN: __________________

Employee Address____

City______________________ State_______________ Zip___________

Effective Date___________________________ **Division**______________________________

Marital Status: Single _______ Married _______ Divorced________ Other____________

Date of Birth______________________

Payroll Frequency: ______________________

Does the employee or family have other insurance coverage through a second carrier? **YES or NO**

Are you enrolled in your employers Health Savings Account? **YES or NO**

SALARY REDIRECTION FOR HEALTH CARE PREMIUMS

In lieu of specified dollar amounts, I hereby elect and authorize any premiums I am obligated to pay, for applicable insurance coverage, for myself and any of my dependents to be deducted from my pay on a BEFORE-TAX basis unless I otherwise direct.

ELECTION OF MEDICAL REIMBURSEMENTS

______I elect to **NOT** receive medical reimbursements for the plan year.

______I elect to receive medical reimbursements for the plan year. (Below must be filled out)

Pay period amount $ _____________ x number of pay periods_______= annual election $___________

Reimbursements will be available for "qualifying medical expenses." I agree to notify the Employer if I have any reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.

If I terminate my employment with the Employer, my contributions and reimbursements shall be subject to the provisions of the Plan Document.

I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction on my tax return.

ELECTION OF DEPENDENT CARE REIMBURSEMENTS

______I elect to **NOT** receive dependent care reimbursement for the year.

______I elect to receive dependent care reimbursement for the year. (Below must be filled out)

Pay period amount $ _____________ x number of pay periods_______= annual election $___________

Reimbursements will be available for "qualifying dependent care expenses." I agree to notify the Employer if I have any reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.

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 amounts 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.

DEPENDENTS INFORMATION (Please provide even if you are not enrolling in dependent care)

Spouse Name___________________________________Date of Birth______________________________

Dependent Name___________________Relationship_________________Date of Birth_________________

Dependent Name___________________Relationship_________________Date of Birth_________________

Dependent Name___________________Relationship_________________Date of Birth_________________

Dependent Name___________________Relationship_________________Date of Birth_________________

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 and it is allowable by my company plan. Change in family status may include, marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my spouse's employment status from full-time to part time or vice versa, my spouse or I taking an unpaid leave of absence, a substantial change in my spouse's employer-sponsored health coverage.

Any amounts that are not used during a plan year to provide benefits will be forfeited, unless your plan has elected a grace period (2.5 month extension) or a roll-over policy and may not be paid to me in cash. If the plan has a grace period, any amounts remaining for a particular plan year will be forfeited after the grace period ends.

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

____ ________________________________

Employee's Signature Date

Accepted and agreed to by the Employer's Authorized Representative.

By:____ Date______________________________