



**Waiver of Pre-Tax Benefits Under the Salary Reduction Plan; Election of After-Tax Benefits (Check box if applicable; do not check this box if you have checked one or more boxes in the section above)**

- I elect to waive all pre-tax benefits under the Plan. I understand that if I have enrolled for Medical Insurance coverage on a separate benefit enrollment form. I will pay my share of the contributions with after-tax payroll deductions. Except for a Change in Election Event for the applicable Benefit (as described below), I understand that I cannot elect pre-tax benefits until the next Open Enrollment Period, and any after-tax coverages shall be outside the Plan.

**Elections Irrevocable Unless Exception Applies**

I understand that I cannot change or revoke this Agreement as of any date prior to the next January 1, unless a Change in Election Event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage, etc.) and the election change is on account of and is consistent with the Change in Election Event, as described in the Plan.

**Additional Terms**

I agree that my Compensation will be reduced by the amount of my required contributions for the Benefits that I have elected under the Plan and that such Salary Reductions will continue for each pay period until this Agreement is amended or terminated. I understand that my contribution for the Medical Insurance Benefits may be automatically increased or decreased for changes by the Plan Administrator. I also understand the following:

- Signing this Agreement does not initiate my coverage under the Medical Insurance Policy. I must complete a separate Medical Insurance enrollment form to start my Medical Insurance coverage.
- Salary Reductions under this Agreement reduce my Compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.
- If any unused amounts remain in my Health FSA Account after reimbursing my eligible expenses incurred during the Plan Year (or incurred during the Plan Year or the 2-1/2 month grace period following the Plan Year), these amounts will be forfeited.
- If any unused amounts remain in my DCAP Account after reimbursing my eligible expenses incurred during the Plan Year, these amounts will be forfeited.
- Prior to December 31 of each year, I will be offered the opportunity again to elect Premium Payment, Health FSA, and DCAP coverage for the following Plan Year. If I do not complete and return a new Agreement at that time, then I will be treated as having elected to waive all pre-tax benefits under the Salary Reduction Plan and my pre-tax coverage will cease at the end of the Plan Year (December 31), subject to any rights I may have to be reimbursed for Medical Care Expenses incurred during the 2-1/2 month grace period following the Plan Year from unused amounts in my Health FSA Account.

**I have read and agree to the terms of participation and to any applicable certifications set forth in the Agreement. Any previous election and agreement under the Plan relating to the same Benefits, including any prior Election Form/Salary Reduction Agreement, is hereby revoked.**

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Date*

*Accepted and agreed to:*

\_\_\_\_\_  
*Plan Administrator's (Employer's) Signature*

\_\_\_\_\_  
*Date*

**Designation of Authorized Representative**

I, the above signed employee do, hereby appoint (please print) \_\_\_\_\_ (hereinafter "my Authorized Representative") to act on my behalf in pursuing a benefit claim specifically pertaining to my Health FSA/ DCAP account(s). My Authorized Representative shall have full authority to act, on my behalf with respect to an initial determination of a Claim, any requests for documents relating to the Claim and any appeal of an adverse determination of a Claim.

I am aware that the Standards for Privacy of Individually Identifiable Health Information set forth by the U.S. Department of Health and Human Services (the "Privacy Standards"), govern access to medical information. I understand that in connection with the performance of his/her duties hereunder, my Authorized Representative may receive my Protected Health Information, as defined in the Privacy Standards, relating to the Claim. I hereby consent to any disclosure of my Protected Health Information to my Authorized Representative.

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Date*

**ACKNOWLEDGEMENT**

***I have read the above Designation of Authorized Representative and I hereby accept and agree to act as Authorized Representative.***

\_\_\_\_\_  
*Authorized Representative's Signature and Address*

\_\_\_\_\_  
*Date*