ADMINISTRATION PROVIDED BY:
Diversified Group
PO Box 299
Marlborough, CT 06447
860-295-0238 x 391
Toll free 888-322-2524

SECTION 125 FLEXIBLE SPENDING
Election Form/Salary Reduction Agreement-GP/DC

Group Name: RFMH, Inc. **Group No.: DAC274G** **Plan Year: 2023**

Last Name: _____ M.:___ First Name: _____

Date of Birth: _____ Sex M/F: _____ Marital Status: _____ Date of Hire: _____

Address: _____ City: _____ ST: ____ Zip: _____-_____

Social Security: _____ **Contribution Start Date: _____**

Spouse Name: _____ DOB: _____ Sex M/F: ___ Soc. Sec. #:_____

Dependent(s):

Name _____DOB: _____ Sex M/F: ____ Soc. Sec. #: _____

Name _____DOB: _____ Sex M/F: ____ Soc. Sec. #: _____

Name _____DOB: _____ Sex M/F: ____ Soc. Sec. #: _____

Name _____DOB: _____ Sex M/F: ____ Soc Sec. #: _____

Name _____DOB: _____ Sex M/F: ____ Soc Sec. #: _____

I have received the terms of the Salary Reduction Plan (with Premium Payment, Health FSA and DCAP Components) ("the Plan"). (Capitalized terms used in this Election Form/Salary Reduction Agreement ('the Agreement") have the meanings set forth in the Plan Document.) I understand that I may elect coverage for the **2023** plan year under any or all of the following Plan Components:

- Health FSA Component, under which I may establish a pre-tax account from which I will be reimbursed for my eligible Medical Care Expenses, up to an annual limit of $3,050.00.
- DCAP Component, under which I may establish a pre-tax account from which I will be reimbursed for my eligible Dependent Care Expenses, up to an annual limit of $5,000.00.

Election of Pre-Tax Benefits Under the Salary Reduction Plan

I elect to receive the following coverages under the Plan. I understand that an amount equal to the annual contributions for the coverages I have elected, divided by the number of pay periods in the Plan year, will be deducted on a pre-tax basis from each of my paychecks (unless another method is prescribed by the Plan Administrator) to pay for the coverages that I elect. (*Check all boxes that apply*)

☐ Health FSA Benefits: $_____/year (annual maximum $3,050.00).

☐ DCAP Benefits: $_____/year (annual maximum $5,000.00).
Income Exclusion for DCAP Benefits: I understand that the amount of DCAP Benefits that I am able to exclude from my income not be more than the $5,000.00 maximum permitted under the Plan. I have no reason to believe that the amount of DCAP Benefits I am electing will exceed my applicable statutory limit. (Note: Your applicable statutory limit is the amount you can exclude from income for DCAP benefits and will depend on your marital status, tax filing status, and your own and your spouse's earned income. For example, certain individuals who are married and file a separate tax return can only exclude $2,500.00 of DCAP Benefits from their income.

Debit Card Certification: I understand that I will be issued a debit card to access benefits from these accounts. I agree only to use the card for Code § 213(d) expenses. I agree to not to use the card for any expenses that have already been reimbursed or for which I intend to apply for reimbursement under another plan. I will acquire and retain all necessary documentation as required by the Plan for any expenses paid by the debit card. I understand that I may be required to submit additional documentation to Diversified Administration Corporation, our Flexible Benefits Administrator, if needed, to further substantiate these claims. I also acknowledge that this certification is reaffirmed each time I use the card. Finally, I agree to reimburse the Plan for any electronic payment made that is not a qualified expense under the Plan.

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 January1, 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.
- I f 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*