Employer Name _____

# Cafeteria / Section 125 Plan Enrollment/Waiver

Plan Year: _____

EMPLOYEE NAME _____ SOCIAL SECURITY NUMBER: _____

HOME ADDRESS _____

Purpose: This agreement is designed to conform with the "Flexible Compensation Plan" pursuant to Section 125 and other pertinent sections of the Internal Revenue Code. The purpose is to permit employees to reduce their salary or compensation and have this reduction for certain qualifying expenses and administrative charges be reimbursed tax free. Participation in the cafeteria plan is not intended to affect any employee contracts. All benefits currently in force based on previous compensation shall be provided as if this salary reduction agreement were not in force.

Please indicate the plans of insurance you desire and the amount of payroll reduction for each plan or reimbursement account in the blanks below.

| | Monthly Premium: | Total Amount *Per Pay Period*: | Your Annual election For*This Plan Year*: |
|---|---|---|---|
| **Insurance Premiums:** | | | |
| Group Health Insurance: | $_____ | $_____ | $_____ |
| _____ | $_____ | $_____ | $_____ |
| _____ | $_____ | $_____ | $_____ |
| **Expense Reimbursement Accounts:** | | | |
| Dependent Care Reimbursement: (Not to exceed $5,000 annually) | | $_____ | $_____ |
| Medical Expenses Reimbursement (Not to exceed $ _____annually) | | $_____ | $_____ |
| **TOTALS:** | | $_____ | $_____ |

I am aware that insurance premiums are subject to change during the plan year. If they do, I hereby elect to change the amounts of my withholdings commensurate with the insurance premiums. Furthermore, I realize that this authorization is irrevocable until the next Plan Year, and that I will be allowed to change the allocation & deduction only if there is a change in my family circumstances, specifically, the gain or loss of a dependent or my spouse's loss or change of employment. This agreement will automatically terminate if the plan is terminated or discontinued or if I cease t receive compensation from the company which, before reduction hereunder, is at least equal to the amount of that reduction. I further realize that any amount remaining in my individual reimbursement account(s) after I have been reimbursed for eligible expenses incurred during the plan year will be forfeited. *I hereby authorize my employer to reduce my earnings by the amounts indicated on this form*.

_____ _____

Signature Date

## WAIVER OF PARTICIPATION

I am aware that I am eligible to participate in my employer's Cafeteria Plan and acknowledge that the opportunity to enroll has been provided to me in accordance with the provisions of the plan. I further acknowledge that I understand the benefits of participating in the plan and that I may not be eligible to enroll in the plan again until the next regular enrollment period. *I voluntarily choose to waive participation in the Cafeteria Plan offered by my employer.*

_____ _____

Signature Date

Accepted by Employer Representative _____ _____

Date

First Payroll Deduction Date _____

**The Benefit Companies, LLC.**
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