INTEGRITY ADMINISTRATORS, INC.
FLEXIBLE BENEFITS PLAN ELECTION & COMPENSATION REDIRECTION AGREEMENT

Employer: _____ ☐ **New Enrollment** ☐ **Change in Status** ☐ **Re-Enrollment** ☐ **Address Change**

Department: _____ **Location:** _____

Election for the Plan Year starting on: _____/_____/_____ **Election Effective Date:** _____/_____/_____

Employee Name

Last Name: _____ **First Name:** _____ **M. I.** _____

Employee Address

Street: _____ **City:** _____ **State** _____ **Zip Code:** _____

S. S. N.: _____-_____-_____ **Date of Birth:** _____/_____/_____ **Date of Hire:** _____/_____/_____

ELECTION OF BENEFITS

In accordance with my rights under the Plan, I elect to allocate the following amounts for each benefit that I selected below. I understand that my compensation for each pay period shall be reduced by the dollar amounts indicated below to create flexible benefit plan dollars during the plan year.

My paychecks are based on the following pay periods: ☐ **Weekly (52)** ☐ **Biweekly (26)** ☐ **Semimonthly (24)** ☐ **Monthly (12)**

The Internal Revenue Service's definition and/or criteria for one of the following applies to me. Please check one box:

☐ **Highly Compensated Employee** ☐ **Key Employee** ☐ **Non Key Employee**

FLEXIBLE SPENDING ACCOUNT OPTIONS	**PAY PERIOD ELECTION AMOUNT**	**TOTAL FOR PLAN YEAR** (*Pay Period Amt. X # of Pay Periods*)
1. ☐ **Premium Conversion Election** *(Your employer may automatically make prospective changes in your Premium Conversion elections if the cost of benefits increase or decrease and such increases or decreases effect the amounts that you are required to contribute for the corresponding coverage.)*	$_____._____	$____,_____._____
2. ☐ **Medical Care Reimbursement Account** *(Maximum $_____ per plan year)*	$_____._____	$____,_____._____
3. ☐ **Dependent/Child Care Reimbursement Account** *(Maximum $5,000 per tax year)*	$_____._____	$____,_____._____
4. ☐ **Individual Insurance Reimbursement Account** *(This option is not offered by all Flex Plans. Contact your Benefits Department before making your election.)*	$_____._____	$____,_____._____

WITH REGARDS TO MY COMPENSATION REDIRECTION AGREEMENT AND MY ELECTION OF FLEXIBLE BENEFITS, I UNDERSTAND THAT:

I may not change elections during the Plan Year unless there is a change in my family status (e.g., marriage, divorce, death of my spouse or child, adoption or birth of my child or termination of employment of my spouse). The Administrator is authorized to adjust the amount of my salary redirections and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured. My election of salary redirections and flexible benefits will remain in effect only during the Plan Year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election not to participate in the Plan for that Plan Year. Any amounts that are not used during a Plan Year to provide flexible benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year. I am solely responsible for notifying my Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualified expense. I also agree to indemnify and reimburse my Employer on demand for any liability it incurs for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive for a non-qualified expense, up to the amount of additional tax actually owed by me. My Social Security benefits may be slightly reduced as a result of my election. In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek the payment of benefits under the terms of the Plan. I therefore designate as my beneficiary under the Plan the following person:

BENEFICIARY DESIGNATION

First & Last Name: _____ **Relationship:** _____

ELECTION TO PARTICIPATE IN THE PLAN

I hereby elect to participate in my Employer's Flex Plan. I understand that this agreement is subject to the terms of my Employer's Flexible Benefit Plan, Medical Care Reimbursement Plan and/or Dependent Care Assistance Plan in effect and as amended from time to time. I also understand that this agreement shall be governed by and construed in accordance with applicable laws and shall take effect under such applicable laws and, to the extent allowed by the law, revokes any prior election and compensation redirection agreement relating to such plan(s) for the corresponding Plan Year. Typing your name is the equivalent to an electronic signature.

X /s/ _____ _____

Employee's Signature ***Date***

DECLINATION TO PARTICIPATE IN THE PLAN

I certify that I have been given the opportunity to participate in my Employer's Flex Plan and have elected not to do so at this time. I understand that by not electing to participate, I will not be able to enroll in the Flex Plan until the next Plan year.

X /s/ _____ _____

Employee's Signature ***Date***

Integrity Administrators, Inc.

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