SALARY REDIRECTION AGREEMENT

EMPLOYER: _____ **EMPLOYER TAX ID NUMBER:** _____
AFFILIATE NAME/LOCATION: _____ **AFFILIATE TAX ID NUMBER:** _____
FLEX ONE® FSA? ☐ **Yes** ☐ **No** **CAFETERIA PLAN YEAR:** / / - / /

Social Security Number: _____ **If new employee, indicate eligibility date:** _____
NAME: (Last) _____ **(First)** _____ **(Middle Initial)** _____
ADDRESS: _____ **CITY/STATE:** _____ **ZIP:** _____
Number of Payroll Cycles in Plan Year: ____ Date of first deduction: _____ Payroll Mode: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

On a separate benefit enrollment form(s), I have enrolled for certain insurance coverage(s) and understand that my insurance premiums and/or Flexible Savings Account(s)(FSA) election amounts will be deducted from my paycheck by my employer or Third Party Payroll Administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an equal amount to the insurance premiums and/or FSA account election amount for each payroll period throughout the plan year. The amount of my required contribution is set forth on a schedule that has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. If the rate change is brought on by the third-party carrier (insurance company), the premium increase or decrease can be deducted pre-tax. "Employer- provided" non-elective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes, therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Flexible Benefits Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

Check the desired coverage(s) below:

	Pre-tax	After-tax		Pre-tax	After-tax
Medical Coverage	_____	_____	Accident Insurance	_____	_____
Dental Insurance	_____	_____	Short-Term Disability Insurance	_____	_____
Vision Care Insurance	_____	_____	Long-Term Disability Insurance	_____	_____
Cancer Insurance	_____	_____	Hospital Indemnity Insurance	_____	_____
Intensive Care Insurance	_____	_____	Personal Sickness Indemnity		
Group Term Life Insurance (if family, must be after-tax)	_____	_____	Other accident or health plan(s) under Section 106 of the Internal Revenue Service Code	_____	_____
Specified Health Event	_____	_____	List: _____	_____	_____

Complete the following section only if participating in a Medical or Dependent Care Reimbursement Plan:

Medical FSA plan: ($ _____ per pay period) x (_____ number of deductions) = $ _____ Annual Election
Dependent Care FSA plan: ($ _____ per pay period) x (_____ number of deductions) = $ _____ Annual Election

I understand and agree that (initial all):

INITIAL On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with **respect to pre-tax premiums before the next anniversary date of the plan** unless a "change in family status" occurs (as defined under the Internal Revenue Code), and the change is caused by and consistent with the "change in family status." **I understand that I cannot revoke any pre-tax election based on a Right to Examine provision as may be contained in any insurance plan or policy issued to me.**

INITIAL Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue. Elections under the Medical and Dependent Care FSA plans will not continue without my completing and submitting a new Salary Redirection Agreement prior to the beginning of each plan year.

INITIAL In addition to and without limiting in any way my employer, the Plan, their service provider (AFLAC and FLEX ONE®) and their respective agents, employees, subcontractors and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status and health and dependent child care information) as is reasonably required to administer the Plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer, the Plan, their service provider (AFLAC and FLEX ONE®) and their respective agents, employees, subcontractors and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of Plan administration or to detect or prevent fraud or misrepresentation.

INITIAL Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverage may be funded on an after-tax basis to preserve the excludability of policy benefits.

INITIAL **FOR MEDICAL AND DEPENDENT CARE FSA PARTICIPANTS:** FOR MEDICAL AND DEPENDENT CARE FSA PARTICIPANT: I verify that I have received a summary of the tax rules, operational guidelines and reimbursement procedures for use in Medical and Dependent Care FSA plans. I understand the plan document will control notwithstanding any contrary oral representation by any person. I understand that reimbursement will be available only for eligible expenses, and I agree to notify the employer if I receive reimbursement for an expense that does not qualify. I also agree, upon demand, to indemnify and reimburse the employer for any liability it may incur for failure to withhold taxes from any reimbursement I receive for non-qualified expenses, up to the amount of additional tax owed by me. Furthermore, I understand that any account surplus at the end of the plan year shall be retained by the employer to offset administrative expenses or future costs, and the obligation to make reimbursements is the responsibility of my employer and not any service provider hired by the employer to assist in processing claims. I understand that I may be responsible for a monthly service fee for Medical and Dependent Care FSA plans and authorize my employer to payroll deduct any required service fee amount.

WAIVER OF PRE-TAX BENEFITS UNDER THE FLEXIBLE BENEFITS PLAN:

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. I elect to **waive all pre-tax benefits** under the plan, and understand that the **benefits may be elected on an after-tax basis**. Except for a change in family status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan. **INITIAL**

EMPLOYEE SIGNATURE: _____ **DATE:** _____

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Copy — White (FLEX ONE) Yellow (Employee) Pink (Employer) Gold (Associate)