You Are Making Elections For the Plan Year
Beginning July 1, 2010
Ending June 30, 2011

FLEXIBLE BENEFITS PLAN ANNUAL ELECTION FORM

Important - You Must Complete and Return An Election Form Each Plan Year - Elections Do Not Continue From Plan Year to Plan Year

PLEASE PRINT

First Middle Initial Last

YOUR NAME: _____ YOUR SOCIAL SECURITY NO: ___/___/___ DATE OF BIRTH: _____

YOUR HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (___) ___-___ WORK PHONE: (___) ___-___ WORK LOCATION/DEPARTMENT: _____

E-MAIL ADDRESS: _____ SPOUSE'S NAME: _____ DATE OF BIRTH: _____

DEPENDENT'S NAMES: (1)_____ (2)_____ (3)_____ (4)_____

DATES OF BIRTH: (1)_____ (2)_____ (3)_____ (4)_____

PART 1 - PAYROLL DEDUCTED INSURANCE PREMIUMS

IMPORTANT INFORMATION CONCERNING YOUR PAYROLL DEDUCTED INSURANCE PREMIUMS

Clarke County automatically deducts all eligible insurance premiums before federal income taxes are calculated. This policy enables your insurance premiums to be treated as "tax-free" benefits to you. Because of this tax-free status, certain rules and limitations will apply on when and under what circumstances you may make changes in your insurance coverages during the year. If for some reason you do not want tax-free benefits during the 2010 Plan Year, you must notify the Finance Department, in writing, prior to July 1, 2010. For more information on the tax treatment of your insurance premiums, please refer to the Plan Overview included with your election materials or call EBS/Atlanta toll-free at 1-800-647-3709.

PART 2 - MEDICAL REIMBURSEMENT ACCOUNT

DO YOU WANT TO ESTABLISH A MEDICAL REIMBURSEMENT ACCOUNT FOR THIS PLAN YEAR? ☐ YES ☐ NO

IF YOU CHECKED THE "YES" BOX, ENTER THE AMOUNT YOU WANT TO CONTRIBUTE IN THE SPACES BELOW –

I ELECT TO ESTABLISH A MEDICAL REIMBURSEMENT ACCOUNT FOR THE PLAN YEAR AND TO CONTRIBUTE $_____ PER PAY PERIOD WHICH IS A TOTAL OF $_____ FOR THE PLAN YEAR).

PART 3 - DEPENDENT CARE REIMBURSEMENT ACCOUNT *(child & elder care)*

DO YOU WANT TO ESTABLISH A DEPENDENT CARE ACCOUNT FOR THIS PLAN YEAR? ☐ YES ☐ NO

IF YOU CHECKED THE "YES" BOX, ENTER THE AMOUNT YOU WANT TO CONTRIBUTE IN THE SPACES BELOW -

I ELECT TO ESTABLISH A DEPENDENT CARE REIMBURSEMENT ACCOUNT FOR THE PLAN YEAR AND TO CONTRIBUTE $_____ PER PAY PERIOD WHICH IS A TOTAL OF $_____ FOR THE PLAN YEAR.

IMPORTANT TERMS AND CONDITIONS

This Election Form is subject to the terms and conditions of Clarke County's Flexible Benefits Plan, in effect and as may be amended from time to time. I understand my election as stated on this Form shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws and revokes any prior election and agreement relating to such Plan. I acknowledge that I have read and understand the terms and conditions printed below and that I have received a copy of the Plan's Summary Description.

- I understand that I cannot change or revoke my election at any time during the Plan Year unless I have a change in family status (including marriage, divorce, death of my spouse or my dependent, birth or adoption of a child, termination of my employment or my spouse's employment), or such other events which may be permitted by Internal Revenue Service Regulations.
- I understand that I must notify the Plan Manager of a change in status within 30 days of the event by completing an Election Change Application and I further understand that, if my Application is approved, the change may not be made retroactive but will become effective on the first pay period following the date of approval.
- I understand that the Plan Administrator may reduce, cancel or otherwise modify my elections in the event it believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- I understand that any reduction in my cash compensation under this Agreement shall be in addition to any reductions under other agreements or benefit plans.
- I understand that should my insurance premiums increase or decrease during the Plan Year, my elections will be adjusted accordingly.
- I understand that reimbursement made under a Medical Reimbursement Account and/or a Dependent Care Reimbursement Account will be available only for "qualifying" expenses as permitted by IRS Regulations. I agree to notify the Plan Administrator if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Plan or my Employer on demand for any liability it may incur for failure to withhold federal, state or local income taxes or social security tax up to the amount of additional tax actually owed by me.
- I understand that prior to the first day of each Plan Year, I will be afforded the opportunity to change my benefit elections for the next Plan Year.

Date: _____ **Employee's Signature:** _____

EBS ATLANTA LOS ANGELES

DISTRIBUTION - WHITE: EMPLOYER CANARY: *EBS/ATLANTA* PINK: *EMPLOYEE*

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