

ELECTION FORM AND SALARY REDIRECTION AGREEMENT

Employee Name: _____ SSN: _____

Plan Year: _____ through _____

As an eligible employee in the above plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected for the plan year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts set forth below for each plan year (or such portion of the year as remains after the date of this agreement). Please check appropriate box(es).

G ELECTION FOR PREMIUM REIMBURSEMENTS

I have enrolled for certain group insurance coverages on the appropriate enrollment forms.

I hereby elect the premium reimbursement account and authorize salary redirection in the amounts of the premiums (or parts of premiums) deemed by responsibility by the City of Traverse City and as I agreed to by signing the payroll deduction authorization form.

I understand that if my required contributions towards premiums for the elected benefits are increased or decreased while this agreement remains in effect, my salary redirection will automatically be adjusted to reflect that increase or decrease.

G ELECTION OF DEPENDENT CARE ASSISTANCE

I elect to receive dependent care assistance for the plan year.

The amount of compensation redirection will be \$ _____ for the plan year.

I understand that: Reimbursement will be available only for "Qualifying dependent care expenses: as described in the Internal Revenue Code Section 129, the plan document and the Summary Plan Description. I agree to notify the Employer 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 Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of non-qualifying expense, up to the amount of additional tax actually owed by me.

I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred.

I agree to provide the Administrator with the name, address, and if applicable, the taxpayer identification number of the service provider. I will only be reimbursed for amount up to the balance in my account at the time of my request.

I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan year.

G ELECTION OF MEDICAL REIMBURSEMENTS

I elect to receive medical reimbursements. The amount of salary redirection will be \$ _____ for the plan year.

I understand that: Reimbursements will be available for “qualifying medical care expenses.” Generally, “qualifying medical care expenses” are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the Employer 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 Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued.

If I cease my employment with the Employer, my participation in the Plan will cease. NO further contributions will be made to the Plan on my behalf, although I may be entitled to reimbursements for claims incurred prior to my date of termination.

I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction on my tax return or which has been covered by insurance.

OTHER TERMS AND CONDITIONS

I understand that: I cannot change or revoke any of my election or this compensation reduction agreement at any time during the plan year unless I have a change in family status, (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in y spouses’ employer-sponsored health coverage, or such other events ad the Plan Administrator determines will permit a change or revocation of an election).

The Plan Administrator may reduce or cancel my salary redirection or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later plan year.

Prior to the first day of each plan year I will be offered the opportunity to change my benefit elections for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit elections then in effect for the new plan year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contributions for the benefit option.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER’S FLEXIBLE SPENDING PLAN, AS AMENDED FROM TIME TO TIME, IN EFFECT, 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 SALARY REDIRECTION AGREEMENT RELATING TO SUCH PLAN.

Employee’s signature: _____ Date: _____