



Election to Participate Agreement - FSA

Name: _____

Address: _____

City, St., Zip: _____

Soc. Sec. # _____ - _____ - _____

In accordance with my rights under the Plan, I elect the following benefits by initialing below and designate the following amounts for each benefit I have selected for the plan year. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for each month and plan year or during such portion of the year as remains after the date of this agreement.

Semi- Monthly Annual Amount Initials

_____ _____ _____ **DCAP** - Dependent Care Expenses - \$5,000 Annual Maximum

_____ _____ _____ **MRA** - Medical Reimbursement Expenses - \$2500 Annual Maximum

Terms and Conditions (Please initial each)

_____ On or after the first day of the plan year, I cannot change or revoke any of my elections or this compensation redirection agreement with Initial respect to my pre- tax benefits before the next anniversary date of the plan unless I experience a change in **family status** (i.e., marriage, divorce, birth or adoption of a child, death of a spouse or child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full time to part time or from part time to full time), and the change is caused by and consistent with the change in **family status**. I understand that I will be able to make change at the next available plan anniversary following 12 months. Prior to the Anniversary Date each year I will be offered the opportunity to change my benefit elections for the new plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to discontinue my elections for the new plan year. In addition, this agreement will continue by its terms in the amount of the required contribution for the benefit option.

_____ I also understand that if my required contributions to pay premiums for the elected benefits are increased or decreased, my compensation redirection will automatically be adjusted to reflect that increase or decrease.

_____ I cannot claim the same Dependent Care expenses on my tax return at the end of the year.

_____ I agree that I am applying for the plans initialed above.

Employee Signature: _____ Date: _____

Important Privacy Policy Notice

1. We do not sell customer information
2. We do not share your information with persons, companies, or organizations, outside of Proves that would use that information to contact you about their own products and services.
3. Within Proves, we communicate to our employees regarding the need to protect customer information. We've established physical, electronic, and procedural safeguards to protect customer information.
4. We expect organizations that provide services on our behalf to keep customer information confidential.