FRANKLIN NORTHWEST CAFETERIA PLAN

Election of Benefits Form

Name (Last, First, MI)			Date
Mailing Address	**City, State, Zip Code**		
Social Security #	**Plan Year**	**School**	
e-mail address (optional):		**PHONE**	

☐ I elect to participate in the Health Care Reimbursement Account for the plan year. (See the "Health Care Reimbursement Worksheet" and list on "Qualifying Expenses")

1. Amount to be deducted each pay period: $_______________
2. Number of pay periods in the Plan Year: x_______________
3. Total for Plan Year (1 x 2): $_______________

☐ I elect NOT to participate in the Health Care Reimbursement Account.

ELECTION OF DEPENDENT CARE ASSISTANCE

☐ I elect to participate in the Dependent Care Assistance Account for the plan year. The maximum amount which may be allocated to the Dependent Care Assistance Account is $5,000. (This limit may be reduced if you are married and you or your spouse are not employed full time or your spouse is a full-time student or your spouse is unable to care for him/herself. Please see the Plan Administrator for details.)

1. Amount to be deducted each pay period: $_______________
2. Number of pay periods in the Plan Year: x_______________
3. Total for Plan Year (1 x 2): $_______________

☐ I elect NOT to participate in the Dependent Care Assistance Account.

WAIVER OF PREMIUM CONVERSION

All employee-paid health insurance premiums will automatically be paid through the Franklin Northwest Cafeteria Plan unless you elect not to participate.

STOP : *Consider your response. Checking this box may not do what you think it will do. Most employees elect to participate in this part of the plan by NOT checking the box. Check this box only if you do not want your insurance premiums deducted on a pre-tax basis.*

☐ I elect NOT to participate in the Premium Payment part of this Plan. This means that all employee-paid premiums will be paid with after-tax dollars, thus receiving no payroll tax savings.

I have read and understand the "Other Terms and Conditions Statement" On page 2 before signing below

Employee's Signature:	Date:

Other Terms and Conditions Statement

I understand that: I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the plan year unless I have a change in status. A change in status includes marriage, divorce, annulment, death of a spouse or dependent, birth, adoption or placement for adoption of a child, change of my employment status or that of my spouse or dependent, my or my spouse's or dependent's change in residence or worksite, change in dependent care cost due to a change in provider or fees (fees not applicable if the care provider is a relative), my spouse's or dependent's change in coverage under their employer's cafeteria plan or other qualified plan (change is not applicable to the health care reimbursement account), my or my spouse's or dependent's change in eligibility for Medicare or Medicaid, or such other events as the Plan Administrator determines will permit a change or revocation of an election. A change must be necessitated by and consistent with the change in status.

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

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

The amount of my compensation redirection for each pay period during the year will be credited to reimbursement accounts or used to pay premiums on insured benefits and such amount will be paid on my behalf or I will be reimbursed, up to the balance in that account, for the applicable expenses incurred during the plan year.

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 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.

Premium Payments for employee-paid insurance premiums offered in this Plan will automatically be paid through this Plan unless I elect **not** to participate prior to the beginning of the Plan Year. Furthermore, I understand that my Employer will furnish me with an "Election Not to Participate" form upon my request.

Health care reimbursement 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 and 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.

If I cease my employment with the Employer, my participation in the Health Care Reimbursement Account will continue if I so elect.
If I elect to continue participation, my salary redirections will continue with after-tax contributions for the remainder of the plan year.
If I elect not to continue participation, no further contributions will be made to the Plan on my behalf, although I may submit claims for expenses incurred during the plan year prior to my date of termination.

I cannot seek reimbursement from this Plan for a medical expense which I intend on taking as a deduction on my tax return.

Dependent care 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 and 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.

I agree to provide the Plan Administrator with the name, address and the taxpayer identification number of my dependent care service provider (if applicable).

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

My reimbursement account elections will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before reduction hereunder, is at least equal to the amount of that reduction.
This agreement is subject to the terms of the Franklin Northwest Cafeteria 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 compensation redirection agreement relating to such plan.

Franklin Northwest Cafeteria Plan

Sworn Statement of Alternative Health Insurance Coverage

Name:	**Social Security #**

The Franklin Northwest Cafeteria Plan requires that you enroll in the health insurance plan, unless you receive alternative medical insurance coverage. If you have alternative coverage, please complete the following, sign and return this form to the Plan Administrator.

Alternative Coverage
Plan Sponsor:
Insurance Company:
Effective for 12-Month Period Beginning:

I certify that I am currently receiving comparable medical benefits as listed above. To the best of my knowledge this coverage is comparable to the health insurance provided by my employer. I understand that the Plan Administrator reserves the right to refuse this statement based on a finding that the alternative coverage is not comparable.

Under penalty of perjury, I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct and complete.

Employee's Signature	**Date**
Authorized Delegate of the Plan Administrator	**Date**