EMPLOYER CAFETERIA PLAN
SALARY REDIRECTION/REDUCTION AGREEMENT

EMPLOYER: _____

EMPLOYER'S TAX ID NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

AFFILIATE'S NAME/LOCATION: _____

AFFILIATE'S TAX ID NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Aflac Benefit Services FSA? ❑ Yes ❑ No **CAFETERIA PLAN YEAR:** ____/____/____ – ____/____/____

(CHECK ONE) ❑ **OPEN ENROLLMENT OR** ❑ **NEWLY ELIGIBLE EMPLOYEE, ELIGIBILITY DATE:** ____/____/____

SOCIAL SECURITY NO.: _____ **DATE OF BIRTH:** ____/____/____ **PHONE:** (____)_____

NAME: (Last) _____ **(First)** _____ **(Middle Initial)** _____

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

E-MAIL: _____

No. of Payroll Cycles in Plan Year: _____ Date of First Deduction: ___/___/___ Payroll Mode: ❑ Weekly ❑ Biweekly ❑ Semimonthly ❑ Monthly

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution and/or Flexible Spending Account(s) (FSA) election amount(s) will be deducted from my paycheck by my employer or a third-party payroll administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage and/or FSA account election amount as prorated for each payroll period throughout the plan year. The amount of my required contribution 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. Amounts corresponding to employer-provided, nonelective 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 below. 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 any premium/contribution amounts hereunder shall evidence acceptance of this agreement.

Check the desired coverage(s) below. (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for any increase/decrease in premium or required contribution) except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage	_____	_____	Specified Health Event Insurance	_____	_____
Dental Insurance	_____	_____	Short-Term Disability Insurance	_____	_____
Vision Insurance	_____	_____	Long-Term Disability Insurance	_____	_____
Cancer Insurance	_____	_____	Hospital Confinement Indemnity Insurance	_____	_____
Hospital Intensive Care Insurance	_____	_____	Personal Sickness Indemnity Insurance	_____	_____
Accident Insurance	_____	_____	Health Savings Account (HSA) §223	_____	_____
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 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

Required acknowledgment to participate in Flexible Benefits Plans:

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Flexible Benefits Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Flexible Benefits Plan.

INITIAL

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

I elect to waive all pre-tax benefits under the Flexible Benefits Plan. Except for a change in 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'S SIGNATURE: _____ **DATE:** _____

IMPORTANT INFORMATION REGARDING PARTICIPATION IN THE FLEXIBLE BENEFITS PLAN

I understand and agree to the following:

- **Restrictions on Election Changes:** 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 status occurs (as defined under the plan and the Internal Revenue Code), and the change is caused by and consistent with the change in status.

- **Commencement of Coverage and Status of Prior Elections:** Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or insurance 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.

- **Use of Personal Information:** In addition to and without limiting in any way the rights my employer; the plan; the service provider; and the 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; the service provider; and the 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.

- **Effect of Pre-Tax Contributions on Benefits Payments:** 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 coverages may be funded on an after-tax basis to preserve the excludability of policy benefits.

- **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 that 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 my employer for any liability it may incur for failure to withhold taxes from any reimbursement I receive for nonqualified 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 my employer and such amounts may (but are not required to) be used to offset administrative expenses or future costs, and that the obligation to make reimbursements is the responsibility of my employer and not any service provider hired by my 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. I acknowledge that in some cases reimbursement for eligible Medical and Dependent Care FSA expenses may be administered through an electronic payment card (“the Card”) and agree to abide by the terms and conditions of the plan with regard to such Card usage, and the electronic payment cardholder agreement, including any fees applicable to the Card, limitations as to Card usage, and the plan’s right to withhold and offset for ineligible claims, etc. I also agree to use the Card exclusively for Medical and/or Dependent Care FSA expenses and to retain paper documentation for any claims paid for by the Card.