LIBERTY NATIONAL LIFE INSURANCE COMPANY
Section 125 Cafeteria Plan
Premium Only Plan

SALARY REDUCTION FORM

I, _____ (Employee), understand that my employer, _____, is allowing me to purchase qualified benefits being offered under my employer's Section 125 Premium Only Plan.

I understand that it is the intent of my employer that this program comply with Section 125 of the Internal Revenue Code and the rules and regulations thereunder.

I understand that the benefits which I select under the Section 125 Premium Only Plan will remain in effect for the entire plan year, and that if the benefit selected involves insurance, an application must be completed and approved by the company issuing the policy. If my required contributions for the selected benefits are increased or decreased while this agreement remains in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease.

I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this program. In most instances, an application for insurance must also be completed.

QUALIFIED BENEFIT ELECTION	Employee cost per pay period
Benefits	
☐ Employer's group term life plan	**$**
☐ Employer's group health plan	**$**
☐ Liberty National Cancer Insurance	**$**
☐ Liberty National Hospital Intensive Care Insurance	**$**
☐ Liberty National Group Term for Life Insurance (employee only)	**$**
☐ Liberty National Accident Protector Plus (employee only)	**$**
☐ Liberty National Hospital Income	**$**
☐ Liberty National Dental Alternative Plan	**$**
☐ Liberty National Vision Plan	**$**
☐ Other	**$**
Total	**$**

Deductions will be:

☐ Weekly (52/yr) ☐ Bi-Weekly (26/yr) ☐ Semi-monthly (24/yr) ☐ Monthly (12/yr) ☐ 9-Month ☐ 10-Month

Employee must write initials in the space next to each statement to verify that he/she understands and agrees to the statement.

_____ Even if there is a "right to examine" or "free look" provision in an insurance program, I understand that the reduction(s) will be in effect for the plan year and cannot be changed unless (initial) I experience a change in my family status.

_____ This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with a change in status (e.g., marriage, divorce, death of a spouse or child, birth or adoption of child, change of (initial) employment of spouse or termination).

_____ Prior to the anniversary date each year I will be offered the opportunity during an election period to add or drop coverages for the following plan year. Unless I modify or revoke this agreement during such an election period, I understand that this agreement will remain in effect (initial) for the following plan year.

_____ I have received a "Summary Plan Description".

I agree to deductions from my paycheck to pay for benefits elected above. Any previous election and Salary Reduction Agreement is hereby revoked.

_____ _____

Employee's Signature Date

ELECTION TO RECEIVE CURRENT COMPENSATION

Complete this part if you do not wish to make an election to receive qualified benefits.

I do not wish to receive qualified benefits under my employer's Section 125 Premium Only Plan, and choose instead to receive current compensation. I have received a "Summary Plan Description".

_____ _____

Employee's Signature Date