Tracy Mazda
Payroll Deduction Authorization Form 2010

Employee Name (Print):

(see payroll deduction worksheet for cost to enroll dependents)

Kaiser 0/2700 Plan (includes H.S.A contribution of $100 per month)	**Employee Cost Per Pay Period**	**Blue Cross Lumenos 3500 (includes H.S.A contribution of $100 per month)**	
Employee Only	$0.00	Employee Only	$0.00
EE + Spouse	$ _____	EE + Spouse	$ _____
EE + Child(ren)	$ _____	EE + Child(ren)	$ _____
EE + Family spouse and child(ren)	$ _____	EE + Family spouse and child(ren)	$ _____
Kaiser $30 co-pay plan		**Assurant Dental (circle one)**	
Employee Only	$0.00	Employee Only	$0.00
EE + Spouse	$ _____	EE + Spouse	$16.23
EE + Child(ren)	$ _____	EE + Child(ren)	$16.08
EE + Family spouse and child(ren)	$ _____	EE + Family spouse and child(ren)	$32.25

Tracy Mazda and I agree that the above-designated amount shall be processed on a pre-tax basis through payroll deductions. By this agreement between Tracy Mazda and myself, I understand the following provisions of the Tracy Mazda Benefit Program:

1. The above election applies to the Plan Year 1/01/10 o 12/31/10 and may not be changed except upon a change in my family status such as: marriage, divorce, death of a spouse or child, birth or adoption of a child, change in spouse's employment such as termination. I have 20 days from the date of the qualifying event to submit paperwork to my employer to make a change.

2. I understand that there is no open enrollment for dental. If I do not add myself and/or my dependents during my initial eligibility period, a late entrant penalty will apply to enroll at a later date unless I show proof of a change in family staus as noted above.

3. I have been made aware of and understand that all of the appropriate documents relating to the Tracy Mazda Benefit Program including the Summary Plan Description, Rate Sheet, Privacy Notice, Initial COBRA Notice and any other relevant Plan Documents or Notices are available to me and my dependents through the broker web site at www.filice.com/benefits/tracymazda. I also understand that if I wish to receive a paper copy of any of the above documents, I may do so free of charge by contacting my Human Resources department.

Employee Signature: _____ **Date:_____**

WAIVER OF PARTICIPATION:

I wish to waive coverage at this time. The plan and its pre-tax benefits have been explained to me. If I wish to participate at a later date, I must wait until the next Plan Year, unless there is a change in my family status (e.g. marriage, birth of a child, etc.) at which time I have 30 days to enroll. _____ Medical _____ Dental

Employee Signature: _____ **Date:_____**