Next Generation ENROLLMENT, INC

Questions? Please contact Next Generation Enrollment at 888-266-1732. Monday through Friday between the hours of 8:30 and 6:00 EST or visit our web site at www.nextgenerationenrollment.com.

Flexible Spending Account Election Form

SECTION 1: EMPLOYEE CONTACT INFORMATION

EMPLOYEE NAME: LAST | FIRST/MIDDLE INITIAL | LAST FOUR DIGITS OF SOCIAL SECURITY NO.

COMPANY NAME | EMAIL ADDRESS ❑ check if new | DAYTIME PHONE NUMBER

HOME ADDRESS: STREET ❑ check if new | CITY | STATE | ZIP

SECTION 2: ELECTION INFORMATION

Health Care

❑ I elect to participate in the Healthcare Reimbursement Plan.

$_____ is my PRE-TAX annual election amount.

❑ I elect NOT to participate.

Dependent Care

❑ I elect to participate in the Dependent-Care Reimbursement Plan.

$_____ is my PRE-TAX annual election amount. *(Maximum amount cannot exceed $5,000 annually. Maximum cannot exceed $2,500 annually for an employee that is married and filing a separate tax return).*

❑ I elect NOT to participate.

Benefit MasterCard

❑ I would like to receive one additional Benefit MasterCard for use by an eligible dependent.

DEPENDENT NAME: LAST | FIRST | MIDDLE INITIAL

LAST FOUR DIGITS OF SOCIAL SECURITY NO. | DATE OF BIRTH

By signing this form, I understand that I am authorizing funds to be taken from my paycheck on a PRE-TAX basis and transferred into my Flexible Spending Account. The amount that I am requesting to be deducted will reduce my annual taxable wages. I understand that my election cannot be changed during the plan year unless I experience a qualifying change in status. I am only eligible to participate in this plan year if I sign and date this enrollment form prior to my effective date of coverage under the plan. I am also fully aware that this plan does not have a "rollover" provision and any funds that I did not claim for reimbursement at the end of the plan year will be forfeited. However, per the Summary Plan Description, I do have a certain amount of time after the end of the plan year or after my termination of employment to obtain reimbursement for expenses that were incurred within the plan year or employment period.

X

EMPLOYEE SIGNATURE VERIFICATION | DATE

SECTION 3: DIRECT DEPOSIT INFORMATION (PLEASE BE ADVISED A COPY OF CANCELLED CHECK IS REQUIRED WITH THIS FORM IN ORDER TO REIMBURSE BY DIRECT DEPOSIT)

DEPOSITORY NAME | BRANCH

CITY | STATE | ZIP

ROUTING NUMBER | ACCOUNT NUMBER | ACCOUNT TYPE

I hereby authorize Next Generation Enrollment, Inc., hereinafter called COMPANY, to initiate credit entries to my account indicated above at the depository financial institution named above, hereinafter called DEPOSITORY, and to credit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

X

EMPLOYEE SIGNATURE VERIFICATION | DATE

SECTION 4: AUTHORIZATION TO USE OR DISCLOSE IDENTIFIABLE HEALTH INFORMATION

I, _____, authorize the use and disclosure of all identifiable health information pertaining to reimbursements I file under the flexible benefits plan by or to my spouse or personal representative, _____. The disclosure of identifiable health information may be made at the request of this individual. This authorization is valid during the plan year for which I am electing to participate in the Flexible Benefits Plan. I understand that I do not have to sign this authorization to be eligible to participate in the Flexible Benefits Plan and I also understand that at any time I have the ability to revoke this authorization.

X

EMPLOYEE SIGNATURE VERIFICATION | DATE

X

SIGNATURE OF SPOUSE OR PERSONAL REPRESENTATIVE | DATE

FOR EMPLOYER USE ONLY:

Employee Division_____Effective Date_____Plan Year Start Date_____End Date_____Date of first paycheck under the plan