EVERGREEN YOUTH & FAMILY SERVICES

FLEXIBLE BENEFITS PLAN

**Election of Life Insurance, Medical Flex and Dependent Care Flex Coverage**

**and**

**Compensation Reduction Agreement**

Name:

Social Security Number:

Address:

City, State, Zip:

On the accompanying benefit enrollment form(s), I have enrolled for certain life insurance and/or medical coverages.

I elect to receive

my life insurance additional coverage

my Health Care Flex

my Dependent Care Flex

Under The Evergreen Youth & Family Flexible Benefits Plan. Any previous election and compensation reduction agreement under the Flexible Benefits Plan relating to the same benefits is hereby revoked.

I and Evergreen Youth & Family Services agree that my regular pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected above, effective       \*

and continuing for each succeeding pay period until this agreement is amended or terminated. This amount of my required contribution for each benefit option selected is set for on a schedule that has been provided to me.

\*The pay reduction may not be effective for any pay period that begins before you have signed this form and returned it to the Plan Administrator.

I understand that:

* I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next October 1, unless that change or revocation is on account of and consistent with a change in my family status (i.e., my marriage or divorce, death of my spouse or dependent, birth or adoption of my child, commencement or termination of employment of my spouse, my or my spouse’s unpaid leave of absence or change from full-time to part-time employment (or vice versa), a significant change in my or my spouse’s health coverage attributable to my spouse’s employment, and such other events as the Plan Administrator determines will permit a change or revocation of an election).
* Prior to October 1 each year I will be offered the opportunity to change my benefit coverage(s) for the following Plan Year (October 1 to September 30). If I do not complete and return a new election form at that time with respect to the coverages listed above, I will be treated as having elected to continue for the new Plan Year those coverages listed above which are in effect for me just prior to the new Plan Year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for those coverages.
* The Plan Administrator may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the Flexible Benefits Plan if the Administrator believes it advisable in order to satisfy certain provisions of the Internal Revenue Code. In addition, adjustment may be made in my pay reduction (or new election may be permitted), to the extent provided in the Flexible Benefits Plan, in the event of an increase or decrease in the cost of coverages provided by an independent third-party provider.
* The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreement or benefit plans.
* Prescriptions written by a doctor for eligible medical flex such as massage therapy, over the counter items, essential oils, weight loss clinics, etc. are valid for one-year from the date the prescription was written. Flex reimbursements cannot be made without a valid prescription on file.

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Employee’s Signature Date

**Accepted and agreed to by Evergreen Youth & Family Services**

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By Date

Please return this form to Plan Administrator.

D. Medical Reimbursement Account – The maximum you can contribute is $3,300 annually for

MEDICAL REIMBURSEMENT ACCOUNT.

I elect to enroll in the Medical Reimbursement Account for unreimbursed medical

Expenses (e.g., eyeglasses, etc.) Please deduct $      per pay period for medical care.

I elect NOT to enroll for the Medical Reimbursement Account.

E. Dependent Care Account – The maximum you can contribute is $5,000 annually for

DEPENDENT CARE ACCOUNT.

I elect to enroll in the Dependent Care Account for Eligible dependent care expenses

(e.g., day care). Please deduct $      per pay period for Dependent Care.

I elect NOT to enroll for the Dependent Care Account.

3. TOTALS

A. Life Insurance (per pay period) $

TOTAL INSURANCE COSTS (1) $

D. Flexible Spending Account (per pay period)

Health Care Account $

Dependent Care Account $

TOTAL Flexible spending (2) $

E. Total Expenses (per pay period)

Add (1) and (2) $