

HICKS FLEXIBLE BENEFIT SYSTEMS  
CAFETERIA PLAN SALARY REDUCTION ELECTION FORM

PLAN NAME: ALBIN ENGINEERING SERVICES, INC. PLAN YEAR: Jan. 2009/Dec. 2009

EMPLOYEE NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIPCODE: \_\_\_\_\_

I hereby elect to receive or to have the plan pay for the following benefits during this plan year. I further authorize my employer to reduce my salary by the amounts shown for these benefits.

For each **pay-period or month**: (circle one)

1) \$ \_\_\_\_\_ for the cost of Medical Reimbursements

2) \$ \_\_\_\_\_ for the cost of Medical Insurance Premiums offered by my employer:

Description/Name: \_\_\_\_\_ \$ \_\_\_\_\_  
Description/Name: \_\_\_\_\_ \$ \_\_\_\_\_

3) \$ \_\_\_\_\_ for the cost of Individually purchased Medical Insurance premiums for myself and my dependents, the policies are not through another employer's health plan; **Attach insurance agreement to this form.**

Description/Name: \_\_\_\_\_ \$ \_\_\_\_\_  
Description/Name: \_\_\_\_\_ \$ \_\_\_\_\_

4) \$ \_\_\_\_\_ for Dependent Care Assistance\* (Auto) If you check "Auto" please provide the following information and attach: **Name of Day Care Provider, Address, and Tax payer ID** (\*\$5,000 max. per year)

5) \$ \_\_\_\_\_ for the cost of Administration Fees (if applicable)

\$ \_\_\_\_\_ Total of Salary Reduction

I hereby acknowledge that I have been offered the opportunity to participate in the Cafeteria Plan provided by my Employer and I hereby: (Initial One)

\_\_\_\_\_ Elect to participate in the Cafeteria Plan  
\_\_\_\_\_ Decline to participate in the Cafeteria Plan

I have read the information on the back page and hereby certify the accuracy of the information provided by this Agreement.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

(over)



## AUTHORIZATION AND ACKNOWLEDGMENT

- A) Employer and I agree that my compensation will be reduced by the amount set forth each month during this plan year, or during the balance of the plan year remaining after the date of this agreement.
- B) I understand that the amount of my salary reduction(s) will be credited to an account for the items shown each month during the plan year, and I will be reimbursed or have the plan pay for those items up to my salary reduction amount, for eligible expenses incurred during that year.
- C) Reimbursements and/or payments will be available only for "qualifying expenses" as described in the plan document. I agree to notify my Employer if I have reason to believe that any expense for which I have been reimbursed or which has been paid on my behalf, is not an eligible expense. I further agree on demand to indemnify and reimburse the Employer for any liability it may incur for failure to withhold any Federal and/or state income taxes or any other taxes which may be due should any expense be paid which is not eligible, up to the amount of the additional tax actually owed plus any penalties which this may have caused the Employer.
- D) I understand that I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status described in the plan document. A change in family status is a change such as a marriage, divorce, death or birth of a family member. The termination or change of employment status of a spouse's employment (i.e. spouse changed from full-time to part-time or vice versa). In the event of any change in family status, I may revoke my prior election form and sign a new agreement if such change is on account of and consistent with a change in family status.
- E) This agreement will automatically terminate if the Plan is terminated or if I cease to receive compensation from the Employer except, as otherwise required under the applicable provision of the Consolidated Omnibus Budget Reconciliation Act of 1986 regarding continuation of health care benefits.
- F) The Administrator may reduce or cancel or otherwise modify this agreement in the event the Administrator feels it is advisable in order to satisfy provisions of the Internal Revenue Code.
- G) The reduction of my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.
- H) I understand that any Reduction Amount or Account Balance which has not been used to pay for eligible benefits incurred during the plan year shall be forfeited.

Upon completion of this Agreement and acceptance by the Employer, I hereby elect to participate in the Cafeteria Plan provided by my Employer. This agreement subject to the terms of the Plan Document, as amended from time to time, shall be governed by and construed in accordance with the laws of the State of California and shall take effect as a sealed instrument under the laws of the State of California, and revokes any prior Election Form or agreement relating to this plan.