

5. The Medical Plan is included in our Cafeteria Plan and is, therefore, covered by Section 125 of the Internal Revenue Code. Once an election for coverage is made, the IRS regulations will not permit a change in this coverage until the next annual enrollment date, unless the change is due to a change in status as listed below and the change in my status and need for election change are consistent, as required under the family status rules:

- marriage; divorce; death of a spouse or dependent; birth of a dependent; birth or adoption of a child; change in number of dependents;
- termination of employment or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; a change in worksite; or any change in employment status that affects eligibility;
- a change in residence for you, your spouse or children;
- or your dependents either satisfies or ceases to satisfy requirements for coverage due to change in age, student status, or any similar circumstances;
- or a change in my or my spouse's employment status.

6. Authorization and Agreement

I have read the information describing the Medical Plan and agree to abide by the terms of the Plan Document. I recognize I must submit signed documents and a Reimbursement Request Form to the Plan's Administrator for the reimbursement of qualified expenses, as determined by the Internal Revenue Code. I further recognize that any unused amounts remaining in my Account after the close of a Plan Year will be forfeited. I understand that I will have a specified time period (determined by the Company) in which to submit qualified expenses following the close of a Plan Year or upon termination of participation. This time period will be communicated to me by the Company.

I understand that this application is only valid for the plan year listed at the top of the application and it does not automatically renew, I must complete a new application for each plan year.

Employee's Signature _____ Date: _____

Received by: _____ Date: _____

Effective Date: _____ Date Sent to Payroll: _____