CBS Administrators
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FLEXIBLE SPENDING ACCOUNT

CAFETERIA PLAN
Election Form and Compensation Reduction Agreement

(company name)

Employee's Name: _____

Employee's Address: _____ City/State/Zip_____

Employee's Social Security Number: _____

Email Address_____

Plan Year __**January 1, 2025**_____ Through _**December 31, 2025**_____

The Company and I hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).

Election and Compensation Reduction Agreement For Coverage Under Group Benefit Plans

I agree to have my portion of the Company's group insurance be provided under Section 125. _____ yes _____No

I understand that:

____ If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation. reduction will automatically be adjusted to reflect that increase or decrease.

____ Prior to the first day of each plan year I will be offered the opportunity to change my benefit election for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to terminate my benefit coverage.

Election of Medical Reimbursements and Compensation Reduction Agreement

I elect to receive medical reimbursements for the plan year.

Amount of Compensation Reduction: $ _____ per each pay period which is a total of $_____ for the plan year. The annual plan limit is **$3,300.00** per participant.

Qualifying Medical Care Expenses

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your Federal Income Tax return with certain exceptions (i.e., health insurance provided by a spouse's employer cannot be reimbursed).

Election of Dependent Care Assistance And Compensation Reduction Agreement

Amount of Compensation Reduction: $ _____ per each pay period which is a total of $_____ for the plan year. This amount cannot exceed the limitation in paragraph 7.

Qualifying Dependent Care Expenses

The expenses are incurred for services rendered after the date of this election and during the plan year to which it applies**.**

1. Everyone for whom you incur the expenses is

   (A) A dependent under age 13 that you are entitled to claim as a dependent on your federal income tax return. Or

   (B) A spouse or another tax dependent who is physically or mentally incapable of caring for himself or herself. Or

   (C) A child or other dependent under the age of 13 whom you are supporting but are not entitled to claim as a dependent only because of a written declaration or decree of divorce.

2. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.

3. If the expenses are incurred for services provided by dependent care center (i.e. a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations

4. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 1 (A) above, or who regularly spends at least 8 hours a day in your household.

5. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.

6. The expenses are not paid or payable to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

7. The reimbursement (when aggregated with all other reimbursements received by you under the Plan during the same year) may not exceed the lesser of the following limits:

   (A) The maximum allowed under the Plan.

   (B) $5,000.00 if you are filling a joint tax return and $2,500.00 if separate returns are filed.

   (C) Your taxable commensuration (after all compensation reductions elections).

   (D) If you are married, your spouse's actual or deemed earned income.

PLEASE LIST ALL DEPENDENTS

NAME	BIRTHDATE	DISABLED
Employee		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes

NOTE: If a dependent is disabled, please provide a doctor's statement as to the dependents condition. The diagnosis is not necessary.

Other Terms and Conditions

I understand that:

I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination, or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election).

The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable to satisfy certain provisions of the Internal Revenue Code.

The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.

The amount of my compensation reduction during the year will be credited to an insurance, medical reimbursement, and/or dependent care assistance account and such amount will be paid on my behalf, or I will be reimbursed for the qualified expenses incurred during the year.

My Social Security benefits may be slightly reduced because of my election.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE COMPANY'S CAFETERIA PLAN, MEDICAL, REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S)

Employee's Signature _____ Date _____

Accepted and agreed to by the Company's Representative.

By: _____ Date: _____