SALARY REDUCTION AGREEMENT
EMPLOYEE ENROLLMENT FORM

Employer Name: ______________________________ *Effective Date:* ____________
Employee Name ______________________________ *Date of Hire:* ____________
Home Address ______________________________ *1st Deduction Pay Date:* ____________
______________________________ *Date of Birth:* ____________
Phone Number ______________________________ *Gender: Male* ___ *Female* ___
Social Security Number ______________________________
E-mail Address ______________________________

I authorize my employer to make the following pre-tax salary reductions (check all that apply):

☐ ELIGIBLE INSURANCE PREMIUM CONTRIBUTIONS

☐ MEDICAL REIMBURSEMENT ACCOUNT (MRA)

$______________ X ______________ = $ ______________
Salary Reduction per Pay Period   Number of Pay Periods   Total Plan Year Election

☐ DEPENDENT CARE ACCOUNT (DCA)

$______________ X ______________ = $ ______________
Salary Reduction per Pay Period   Number of Pay Periods   Total Plan Year Election
(Not to exceed $5,000 for Married couples filing jointly or $2,500 if married filing separately)

☐ **I choose not to participate in the Section 125 Medical Reimbursement Account or the Dependent Care Account.**

To provide spouse and dependents with a CBI® Flex Card, complete the separate form "Spouse and Dependent CBI® Flex Card Request/Change Form".

I understand that the choice I have indicated above will stay in effect for the remainder of the plan year, unless I have a qualifying change in my family status. I also understand that the amounts specified or implied above will reduce my pay in equal installments.

Should the amount represented by my choices as indicated above exceed my gross wages for any given pay period, I authorize my employer to carry forward the balance and recoup the balance and any prior outstanding balance from subsequent pay periods.

I also authorize my employer to deduct the balance through the current month from my final pay check in the event I terminate employment.

I have read the Section 125 summary plan description that explains how a Section 125 plan works, the restrictions and other considerations. I also understand that I must save receipts for all expenses in the event they are requested to substantiate a claim.

Signature: ______________________________ Date: ____________________

SPOUSE AND DEPENDENT

CBI® FLEX CARD REQUEST/ CHANGE FORM

Employer Name: ______________________________________
Employee Name ______________________________________
Social Security Number ________________ *Date of Birth* ____________
E-Mail Address ______________________________________

Complete for a spouse or dependent 18 years or older for whom you would like a CBI® Flex Card issued or inactivated.

NAME	SOCIAL SECURITY NUMBER	RELATION	GENDER Male	GENDER Female	DATE OF BIRTH	ADD	DELETE

Spouse/dependent CBI® Flex Cards can only be requested for spouse/dependents that meet federal IRS guidelines. I understand that it is my responsibility to ensure that my spouse and dependents use the CBI® Flex Card for eligible expenses as defined by my employer's Section 125 Flexible Spending Account Plan. I also understand that these expenses must qualify for reimbursement under the Internal Revenue Code and that they cannot be claimed as credits or expenses on my personal income tax return.

I have read the Section 125 summary plan description that explains how a Section 125 plan works, the restrictions and other considerations.

Signature: ______________________________ Date: ________________

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