

THE UNIVERSITY OF TOLEDO
FLEXIBLE BENEFIT PLAN
Election Form and Compensation Redirection Agreement

Open Enrollment 2008
____ Main Campus
____ Health Science

Employee Name: _____ Effective Date: _____
Rocket No.: R _____ S.S.N. _____
Employee Address: _____
Street City State Zip

Plan Year: January 1, 2009 through December 31, 2009

Plan Restatement Date: January 1, 2009

In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the Plan Year (or during such portion of the year as remains after the date of this agreement).

ELECTION OF MEDICAL EXPENSE REIMBURSEMENTS (maximum \$3,000)
(Please note that this is not available for those participating in the Aetna CDHP)

I elect to receive health care reimbursements for the Plan Year. Amount of compensation redirection:

Annual Election: \$ _____ No. Of Pays: _____ = Per/Pay Amount: \$ _____

| | | |
|----------------------------------|---------------------|--------------------------------|
| <u>Open Enrollment</u> | <u>New Hire</u> | |
| 9-month faculty = 18 pays | # of remaining pays | First Pay Date Deducted: _____ |
| 12-month faculty/staff = 24 pays | | (for Benefits Dept.) |

I understand that:

Reimbursements will be available only for "qualifying medical care expenses." "Qualifying Medical Care Expenses" are the same medical expenses deductible on your federal income tax return, with a few exceptions. See the Medical Expense Reimbursement Worksheet for some of those exceptions. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.

ELECTION OF DEPENDENT CHILD CARE ASSISTANCE (Max \$5000 - See IRS Guidelines for more details)

I elect to receive dependent child care assistance for the Plan Year. Amount of compensation redirection:

Annual Election: \$ _____ No. Of Pays: _____ = Per/Pay Amount: \$ _____

| | | |
|----------------------------------|------------------|--------------------------------|
| <u>Open Enrollment</u> | <u>New Hire</u> | |
| 9-month faculty = 18 pays | # remaining pays | First Pay Date Deducted: _____ |
| 12-month faculty/staff = 24 pays | | (for Benefits Dept.) |

I understand that:

Reimbursement will be available only for qualifying dependent care expenses as described in the Internal Revenue Code Section 129, the Plan Document and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state, local income tax or Social Security tax from any reimbursement I receive for a non-qualifying expense, up to the amount of additional tax actually owed by me.

I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred. I also agree to provide the Administrator with the name, address and, if applicable, the taxpayer identification number of the service provider.

This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least twice the amount of that redirection.

(over)

OTHER TERMS AND CONDITIONS

I understand that:

- I cannot change or revoke this compensation redirection agreement at any time during the Plan Year unless I have a qualified status change which may include marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment for my spouse or dependent; a reduction or increase in hours of employment for me, my spouse, or dependent; a strike or lockout; if I or my spouse take an unpaid leave of absence; a change in the cost of my daycare provider; or an event that causes my dependents(s) to satisfy or cease to satisfy the requirements under the health plan under which I receive coverage. **Changes in Daycare Elections are limited to those that are underlined.** Requested changes in coverage must take place within 30 days of the event and be consistent with the life-changing event.
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The redirection of my cash compensation under this agreement shall be in addition to any redirection under other agreements or benefit plans.
- The amount of my compensation redirection will be credited to an insurance, health care reimbursement, and/or dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed for the applicable expenses incurred during the Plan Year.
- Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S FLEXIBLE BENEFIT PLAN, HEALTH CARE REIMBURSEMENT AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDIRECTION AGREEMENT RELATING TO SUCH PLAN(S).

Employee's Signature: _____ Date: _____

Accepted and agreed to by the Employer's Authorized Representative.

By: _____ Date: _____

DESIGNATION OF BENEFICIARY

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek the payment of benefits under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

Name: _____

Address: _____

Relationship: _____

WAIVER OF PARTICIPATION

This waiver will acknowledge that I have been informed of the terms of the above referenced Plan. Even though I am eligible to participate in such Plan, I hereby elect not to participate. I understand that this waiver will remain in effect for the remainder of the plan year for which this election is effective, but that I may again decide to participate in later plan years by making an election to participate during the election period prior to each Plan Year. This waiver is effective for the Plan Year running from

_____, 2009 to _____, 2009.

Employee's Signature: _____ Date: _____

Accepted and agreed to by the Employer's Authorized Representative.

By: _____ Date: _____