EMPLOYER CAFETERIA PLAN
SALARY REDIRECTION/REDUCTION AGREEMENT

EMPLOYER: _____

EMPLOYER'S TAX ID NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

AFFILIATE'S NAME/LOCATION: _____

AFFILIATE'S TAX ID NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Aflac Benefit Services FSA? ❑ Yes ❑ No CAFETERIA PLAN YEAR: ___/___/___ - ___/___/___

(CHECK ONE) ❑ OPEN ENROLLMENT OR ❑ NEWLY ELIGIBLE EMPLOYEE, ELIGIBILITY DATE: ___/___/___

SOCIAL SECURITY NO.: _____ DATE OF BIRTH: ___/___/___ PHONE: (___)_____

NAME: (Last) _____ (First) _____ (Middle Initial) _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL: _____

No. of Payroll Cycles in Plan Year: _____ Date of First Deduction: ___/___/___ Payroll Mode: ❑ Weekly ❑ Biweekly ❑ Semimonthly ❑ Monthly

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution and/or Flexible Spending Account(s) (FSA) election amount(s) will be deducted from my paycheck by my employer or a third-party payroll administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage and/or FSA account election amount as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to employer-provided, nonelective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible Benefits Plan as elected in the Pre-Tax column below. Any previous election and Salary Redirection Agreement under the Flexible Benefits Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/contribution amounts hereunder shall evidence acceptance of this agreement.

Check the desired coverage(s) below. (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for any increase/decrease in premium or required contribution) except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage	_____	_____	Specified Health Event Insurance	_____	_____
Dental Insurance	_____	_____	Short-Term Disability Insurance	_____	_____
Vision Insurance	_____	_____	Long-Term Disability Insurance	_____	_____
Cancer Insurance	_____	_____	Hospital Confinement Indemnity Insurance	_____	_____
Hospital Intensive Care Insurance	_____	_____	Personal Sickness Indemnity Insurance	_____	_____
Accident Insurance	_____	_____	Health Savings Account (HSA) §223	_____	_____
Group Term Life Insurance (if family, must be after-tax)	_____	_____	Other accident or health plan(s) under Section 106 of the Internal Revenue Service Code List: _____	_____	_____

Complete the following section *only* if participating in a Medical or Dependent Care Reimbursement Plan:

Medical FSA Plan: ($ _____ per pay period) x (_____ number of deductions) = $ _____ Annual Election

Dependent Care FSA Plan: ($ _____ per pay period) x (_____ number of deductions) = $ _____ Annual Election

Required acknowledgment to participate in Flexible Benefits Plans:

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Flexible Benefits Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Flexible Benefits Plan.

INITIAL

WAIVER OF PRE-TAX BENEFITS UNDER THE FLEXIBLE BENEFITS PLAN:

I elect to waive all pre-tax benefits under the Flexible Benefits Plan. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

INITIAL

EMPLOYEE'S SIGNATURE: _____ **DATE:** _____