Anderson, Williams, McKinnis & Co. Inc.

Section 125 Cafeteria Plan Salary Reduction Agreement

Company Name _____ Effective Date _____

Employee Name (Last, First) *Please Print* _____ Social Security Number _____

Employee Street Address _____ City _____ State _____ Zip Code _____

Email Address (required) _____ Date of birth _____

Reimbursement Plans

Health FSA..... $_____ per year
*Annual maximum - **$3,300.00***

Dependent Care Assistance Plan* ..... $_____ per year
Annual maximum - $5,000.00

I understand that the debit card is restricted to certain merchant categories and is not accepted at all credit card acceptance locations. I understand that I may not obtain a cash advance with the debit card at any merchant, bank or ATM. I understand that the debit card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which I participate. If the debit card is issued pursuant to Employer Plans and I use the card for an expense that is not a Qualified Expense, or if I use more funds that allowable to my plan(s), I am indebted to my Employer and must repay the full amount of the non-qualified expense. Payment may be made in the form of an offsetting claim, personal check, a post-tax deduction from my paycheck or any other options established by my employer. *Each card is valid for three (3) years, so new cards do not need to be issued each year at open enrollment.

_____ _____

Print Name as it will appear on additional Card (optional)

Direct Deposit information required for DCAP plan

Routing Transit Number
(All nine boxes must be filled.)

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Account Number
(Do not include hyphens, spaces or special symbols)

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THE DEPENDENT CARE WILL AUTOMATICALLY BE REIMBURSED PER PAY PERIOD VIA DIRECT DEPOSIT. NO CLAIM FORM IS REQUIRED SINCE THIS IS REPORTED ON FEDERAL INCOME TAX RETURNS

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown above. I understand this salary reduction agreement will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are consistent with a change in my family status. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code.

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate**.

Signature_____ Date_____