PRIMARK
BENEFITS

Medical Reimbursement Benefit Election

Irrevocable Election. If you elect to participate in the Plan, you can **not** change or revoke your election (including your health insurance coverages) until the Open Enrollment period for the next Plan Year. The only exception is that you may change your election because of a valid change in family status as described in the Plan (Examples: marriage, divorce, death of your spouse or child, birth or adoption of a child, termination of employment of your spouse, switch from part-time to full-time employment or from full-time to part-time employment, beginning or returning from an unpaid leave of absence).

Plan Year beginning: _____ and ending _____

Employer: _____

Name: _____ Social Security #: _____

Address: _____

Election to Participate in the MEDICAL REIMBURSEMENT PLAN

I elect to participate pursuant to the terms of the MEDICAL REIMBURSEMENT PLAN for the Plan Year indicated above. I authorize my Employer to reduce my compensation each pay period on a pre-tax basis by the amount indicated in the space provided below:

$ _____ per pay period

Employee Statement and Signature

A copy of the Summary Plan Description of the MEDICAL REIMBURSEMENT PLAN has been furnished to me. I have read and understand the important information in the Summary Plan Description (and the information above on this Election Form) about the effect of my election.

I acknowledge and understand:

1. This election is **irrevocable** for the stated Plan Year unless I have a change in family status as defined in the Cafeteria Plan.
2. The Employer will reimburse me for dependent care expenses as defined in the Dependent Care Plan with satisfactory proof of expense and only to the amount in my dependent care reimbursement account.
3. If my expenses for a Plan Year are less than the amount of compensation for the Plan Year I elect to reduce, I will forfeit the excess amount.
4. This election revokes any prior election I have made.
5. My termination of employment with the Employer revokes my election to reduce my compensation.

This Election Form is subject to the terms of the Plan as in effect from time to time and shall be governed by and construed in accordance with the laws of the State of California to the extent not superseded by Federal law.

Signature: _____ Date: _____

Primark Benefits
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