**DISCLOSURE STATEMENT**

I understand that my election and participation made herein is voluntary and that I cannot disenroll during the plan year, and may be changed only as of July 1 of each year or in the event of a change in family status. The Health Care Reimbursement account only allows increases for the family status changes; no mid-plan year reductions are permitted. The requested change must be submitted within 31 days of family status change to the HR Insurance/Benefits Division. Furthermore, I am aware that my expenses paid through the pre-tax benefit plans are no longer eligible for credits under the federal or state income tax purposes.

I understand that any amounts remaining in my account(s) at the end of the plan year (including the 90 days grace period), that are not used for eligible expenses incurred during the plan year, will be forfeited in accordance with current plan provisions and tax laws. I further understand that if I terminate employment during the plan year, I will have 90 days from date of termination to submit claims incurred while a participant. After 90 days, I forfeit any account balance.

**Authorization:** I certify the above information to be correct and true and any dependents for which I have selected reimbursement benefits reside with me and/or are legally dependent on me (based on IRS regulations) for their support. 100 percent of the premiums for the spending accounts are my responsibility.
Direct Deposit Authorization  
B.A.S.I.C.FLEX Cafeteria Plan

Please print:

Employer Name: ________________________________

Employee Name: ________________________________

Employee Social Security Number: ________________________________

Internet E-Mail Address: ________________________________

Please direct deposit my Medical and/or Dependent Care Reimbursement into the following:

Select one: □ Checking Account □ or □ Savings Account □

Financial Institution: ________________________________

You MUST attach a voided check for the account into which you are directing the deposits.  
(Deposit slips are not acceptable.) Direct deposits will begin approximately 2 weeks after 
we receive this information from your employer.

I understand that ALL reimbursements will be direct deposited into my account. My 
commitment to direct deposit is for the entire plan year.

Employee Signature: ________________________________ Date: ____________

Please tape voided check in this space.