Election Form and Compensation Redirection Agreement

La Sierra UNIVERSITY

Payroll Office
4500 Riverwalk Parkway
Riverside, CA 92515
(951)785-2034

INSTRUCTIONS: Please read this agreement carefully, fill out the application blanks and indicate the options in which you would like to participate. Sign, date and return this agreement to your Plan Adminstrator.

Employee Name: _____	Social Security Number: _____

Address: _____

City: _____	State: _____	Zip: _____
Telephone Number: _____	Employee Number: _____	Plan Year Ending: _____

The Company and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year (or during each portion of the year as remains after the date of this agreement).

☐ **Health Care Reimbursement Account**

I elect to have $_____ per year, $_____ per pay period reduced from my salary before taxes to reimburse me for eligible health care expenses which I incur during the plan year. The health care maximum contribution is $1500.00.

☐ **Dependent Care Reimbursement Account**

I elect to have $_____ per year, $_____ per pay period reduced from my salary before taxes to reimburse me for eligible dependent care expenses which I incur during the plan year. The health care maximum contribution is $5000.00 ($2500.00 if married filing separately).

Employee Certification

I have read this form and the other enrollment materials and understand that:

* I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a change in family status.
* The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
* The reduction in cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.
* The amount of my compensation reduction during the year will be credited to an insurance, medical reimbursement, and/or dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed for the qualified expenses incurred during the year.
* Any amounts remaining in my reimbursement accounts at the end of the year will be forfeited.
* My Social Security benefits may be slightly reduced as a result of my election.

Employee Signature	Date

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

By	Date