TOWN OF WILBRAHAM
FLEXIBLE BENEFITS PLAN

ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT

Employer Name: TOWN OF WILBRAHAM

Employee Name: _____

Employee Address: _____

Employee Social Security Number: XXX-XX-____

Employee Number: N/A

Plan Year JULY 1, 2013 through JUNE 30, 2014

As an eligible employee in the above Plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

In accordance with my rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected for the Plan Year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts set forth below for each pay period and Plan Year (or during such portion of the year as remains after the date of this agreement).

ELECTION FOR INSURED BENEFITS

On the appropriate benefit enrollment form(s), I have enrolled for certain insurance coverages.

I elect to receive the following coverage under the Cafeteria Plan:

	COVERAGE	PREMIUM PER _____
_____	Dental coverage	$ _____
_____	Life insurance coverage	$ _____
_____	Health coverage	$ _____

(X) In lieu of specified dollar amounts, I hereby elect the above specified insurance coverages and authorize salary redirections in the amounts of current premiums being charged.

I understand that if my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect that increase or decrease.

ELECTION OF HEALTH FLEXIBLE SPENDING ACCOUNT

( ) I elect to participate in the Health Flexible Spending Account for the Plan Year.

Salary Redirection: The amount of compensation redirection will be $_____ for the Plan Year.

NOTE: The annual plan limit which may be allocated to the Health Flexible Spending Account is $2,500.00

I understand that:

-- Reimbursements will be available only for "qualifying medical care expenses" for yourself, your spouse and dependents. Generally, "qualifying medical care expenses" are those medical, dental and/or vision expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation) or otherwise allowed by law. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.

-- Claims must be submitted within 60 days after the end of the Grace Period.

-- This section of the agreement will automatically terminate if the Plan is terminated or discontinued.

-- If I cease my employment with the Employer, my participation in the Health Flexible Spending Account will be subject to the continuation coverage rules of COBRA.

-- If I incur a change in status, I may only increase the amount I have directed towards my Health Flexible Spending Account.

-- I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction or credit on my tax return.

Women's Health and Cancer Rights: This plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

ELECTION OF DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

( ) I elect to participate in the Dependent Care Flexible Spending Account for the Plan Year.

Salary Redirection: The amount of compensation redirection will be $_____ for the Plan Year.

I understand that:

-- Reimbursement will be available only for "qualifying dependent care expenses" as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.

-- I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred.

-- I agree to provide the Administrator with the name, address, and if applicable, the taxpayer identification number of the service provider.

-- This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year.

-- I will only be reimbursed for amounts up to the balance in my account at the time of my request.

-- I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this Dependent Care Flexible Spending Account.

-- Claims must be submitted within 60 days after the end of the Grace Period.

OTHER TERMS AND CONDITIONS

I understand that:

-- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the Plan Year unless I have a change in status and my election is consistent with such change.

-- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

-- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

-- Any amounts that are not used during a Plan Year (or Grace Period, if applicable) to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later Plan Year.

-- Prior to the first day of each Plan Year I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my insured or self-funded benefit elections then in effect for the new Plan Year but not my non-insured benefits. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for the benefit option.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S CAFETERIA PLAN, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN.

_____ Date _____

Employee's signature

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

By: _____ Date _____