



TO: _____

FROM: Carol Kilgore, CPP
Senior HR/PR Manager

DATE: _____

RE: **NEW BABY – YOU ONLY HAVE 31 DAYS FROM THE
DATE OF BIRTH TO MAKE CHANGES TO YOUR
BENEFITS**

Congratulations on your new arrival! Please find attached a number of documents which you may need to complete in order to ensure that Human Resources/Payroll have current information with regard to your new baby.

1. **Employee Information Sheet** – Please complete if you have changed your name, address, or wish to change the individual(s) whom we should contact in case of an emergency.
2. **W-4** – Please complete if you have changed your name (new social security card required), address or wish to change exemptions.
3. **State Withholding Form** – If applicable, you can find your state withholding form on Trends website/HR or contact me directly. The form must be completed if you changed your name (new social security card required), address or wish to change exemptions.
4. **Direct Deposit Form** – Please complete only if wish to change banking information.
5. **401(k) Designation of Beneficiary** – As required by law, your spouse will be your Primary Beneficiary. However, understand that you can designate a Primary Beneficiary other than your spouse if your spouse signs the section “Consent of Spouse”.
6. **401(k)** – Use this form to change your name, address, elections, etc.
7. **Anthem Change Form - Health/Rx/Dental/Vision** – Must be completed if you are adding dependent(s).
8. **Anthem Company Paid Life Insurance** – Use the Anthem Change Form if you wish to change/update your beneficiary(s).
9. **Unum (Voluntary Benefits)** – If you are enrolled in Supplemental Life and/or Accident/Critical Illness voluntary benefits, please complete this form for name and/or address change. Your coverage's can not be changed until Open Enrollment, which are as follows:
 - Unum Supplement Life – April 1st through May 31st annually.
 - Unum Accident/Critical Illness – October 1st through October 31st annually.
10. **Health Savings Account/Employee Contributions** – If you are enrolled in the Health Savings Account and wish to change your employee contribution, please complete this form.

- 11. Flexible Benefits Election/Change Form** – If you are enrolled and wish to change your flex spending contribution(s), please complete this form.
- 12. Flexible Spending Account** – If you wish to enroll, please complete this form.

If you should need additional information or if I can be of further assistance, please do not hesitate to contact me at (317) 388-4007.

EMPLOYEE INFORMATION SHEET

NAME: _____

HIRE DATE: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____

LOCAL/COUNTY: _____

STATE: _____

ZIP CODE: _____

HOME TELEPHONE: _____

CELL PHONE: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

ALTERNATE PERSON TO BE CONTACTED IN CASE OF EMERGENCY

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

HOSPITAL PREFERENCE: _____

FAMILY PHYSICIAN: _____ PHYSICIANS PHONE NUMBER: _____

ALLERGIES OR SIGNIFICANT FACTS THAT TREATING PARAMEDICS SHOULD
KNOW: _____

BLOOD TYPE (IF KNOWS): _____

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	
B	Enter "1" if: { • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. }	B	
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$65,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child	G	
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ► H	H	
For accuracy, complete all worksheets that apply.		{ • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.	

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

OMB No. 1545-0074

2015

► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5	
6 Additional amount, if any, you want withheld from each paycheck	6	\$
7 I claim exemption from withholding for 2015, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here	7	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature

(This form is not valid unless you sign it.) ►

Date ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)
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Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over \$309,900 and you are married filing jointly or are a qualifying widow(er); \$284,050 if you are head of household; \$258,250 if you are single and not head of household or a qualifying widow(er); or \$154,950 if you are married filing separately. See Pub. 505 for details	1	\$ _____
2	Enter: { \$12,600 if married filing jointly or qualifying widow(er) \$9,250 if head of household \$6,300 if single or married filing separately }	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3	\$ _____
4	Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2015 Form W-4</i> worksheet in Pub. 505.)	5	\$ _____
6	Enter an estimate of your 2015 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter "-0-"	7	\$ _____
8	Divide the amount on line 7 by \$4,000 and enter the result here. Drop any fraction	8	\$ _____
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9	\$ _____
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	\$ _____

Two-Earners/Multiple Jobs Worksheet (See Two earners or multiple jobs on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	\$ _____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3"	2	\$ _____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	\$ _____
Note.	If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.		
4	Enter the number from line 2 of this worksheet	4	\$ _____
5	Enter the number from line 1 of this worksheet	5	\$ _____
6	Subtract line 5 from line 4	6	\$ _____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$6,000	0	\$0 - \$8,000	0	\$0 - \$75,000	\$600	\$0 - \$38,000	\$600
6,001 - 13,000	1	8,001 - 17,000	1	75,001 - 135,000	1,000	38,001 - 83,000	1,000
13,001 - 24,000	2	17,001 - 26,000	2	135,001 - 205,000	1,120	83,001 - 180,000	1,120
24,001 - 26,000	3	26,001 - 34,000	3	205,001 - 360,000	1,320	180,001 - 395,000	1,320
26,001 - 34,000	4	34,001 - 44,000	4	360,001 - 405,000	1,400	395,001 and over	1,580
34,001 - 44,000	5	44,001 - 75,000	5	405,001 and over		1,580	
44,001 - 50,000	6	75,001 - 85,000	6				
50,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 100,000	10	140,001 and over	10				
100,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Federal Earned Income Tax Credit (EITC) Notification

Effective January 1, 2008, all employers are required to notify all of their employees of the federal Earned Income Tax Credit (EITC).

Assembly Bill 650, Stats. 2007, Ch. 606, (Lieu and Jones) requires any employer, who is subject to, and is required to provide unemployment insurance to employees, to notify all employees that they may be eligible for the EITC. Employers shall give notification within one week before or after, or at the same time, they provide employees with an annual wage summary (IRS Form W-2, 1099).

NOTICE TO EMPLOYEES

"Based on your annual earnings, you may be eligible to receive the earned income tax credit from the federal government. The earned income tax credit is a refundable federal income tax credit for low-income working individuals and families. The earned income tax credit has no effect on certain welfare benefits. In most cases, earned income tax credit payments will not be used to determine eligibility for Medicaid, supplemental security income, food stamps, low-income housing or most temporary assistance for needy families payments. Even if you do not owe federal taxes, you must file a tax return to receive the earned income tax credit. Be sure to fill out the earned income tax credit form in the federal income tax return booklet. For information regarding your eligibility to receive the earned income tax credit, including information on how to obtain the IRS Notice 797, or any other necessary forms and instructions, contact the Internal Revenue Service at 1-800-829-3676 or through its Web site at www.irs.gov."



Department of the Treasury Internal Revenue Service

Notice 797

(Rev. December 2014)

Possible Federal Tax Refund Due to the Earned Income Credit (EIC)

What Is the EIC?

The EIC is a refundable tax credit for certain workers.

Who May Claim the EIC?

You may be able to claim the EIC for 2014 if you worked and all four of the following conditions apply.

1. You (and your spouse, if filing a joint return) have a valid social security number (SSN) issued by the Social Security Administration. For more information on valid SSNs, see Pub. 596, Earned Income Credit (EIC).
2. Your 2014 earned income and adjusted gross income are both under \$38,511 (\$43,941 if married filing jointly) if you have one qualifying child; under \$43,756 (\$49,186 if married filing jointly) if you have two qualifying children; under \$46,997 (\$52,427 if married filing jointly) if you have three or more qualifying children; or under \$14,590 (\$20,020 if married filing jointly) if you do not have a qualifying child. For a definition of earned income, see the 2014 instructions for Form 1040, 1040A, or 1040EZ.
3. Your filing status on your 2014 tax return is any status except married filing a separate return.

4. You were not a qualifying child of another taxpayer in 2014.

If you **do not** have a qualifying child, you must also meet these conditions.

- a. You, or your spouse if filing a joint return, were at least age 25 but under age 65 at the end of 2014. (You meet this condition if you, or your spouse if filing a joint return, were born after December 31, 1949, and before January 2, 1990.) If your spouse died in 2014, see Pub. 596.
- b. You cannot be claimed as a dependent on someone else's 2014 tax return.

- c. Your home, and your spouse's if filing a joint return, was in the United States for over half of 2014. If you are in the military on extended active duty outside the United States, your home is considered to be in the United States during that duty period and you may be able to claim the EIC.

You **cannot** claim the EIC if any of the following conditions apply.

1. Your 2014 investment income (such as interest and dividends) is over \$3,350. See Pub. 596 for more information.
2. You file either Form 2555 or Form 2555-EZ (relating to foreign earned income).
3. You were a nonresident alien for any part of 2014 unless you were married to a U.S. citizen or resident and elected to be taxed as a resident alien for the entire year. See Pub. 519, U.S. Tax Guide for Aliens, for more information.

(Continued on back)

Who Is a Qualifying Child?

Any child who meets all four of the following conditions is a qualifying child.

1. The child is your son, daughter, stepchild, foster child, brother, sister, half brother, half sister, stepbrother, stepsister, or a descendant of any of them (for example, your grandchild, niece, or nephew). An adopted child is always treated as your own child. An adopted child includes a child lawfully placed with you for legal adoption. A foster child is any child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
2. At the end of 2014, the child was under age 19 and younger than you (or your spouse, if filing jointly); or under age 24, a student, and younger than you (or your spouse, if filing jointly); or any age and permanently and totally disabled.
3. The child lived with you in the United States for over half of 2014. If the child did not live with you for the required time, there are exceptions if the child was born or died during the year, the child is presumed to have been kidnapped by someone who is not a family member, or there was a temporary absence.
4. The child does not file a joint income tax return for 2014.

There are additional rules if a child is married or is the qualifying child of more than one person. For details, see the 2014 instructions for Form 1040, 1040A, or 1040EZ.

How Do You Claim the EIC?

If you are eligible, claim the EIC on your 2014 income tax return. If you have a qualifying child, you must also fill in Schedule EIC and attach it to your Form 1040 or Form 1040A.

If eligible, you can claim the EIC to get a refund even if you have no tax withheld from your pay or owe no tax. For example, if you had no tax withheld in 2014 and owe no tax but are eligible for a credit of \$800, you must file a 2014 income tax return to get the \$800 refund.

More Information

This notice provides the basic requirements to qualify for the EIC. Refer to the instructions for Form 1040, 1040A, or 1040EZ; Pub. 596; or www.irs.gov/eitc for details. You can get IRS forms and publications at IRS.gov or by calling 1-800-829-3676.

**FOR STATE, COUNTY, CITY AND/OR TOWNSHIP
FORMS, PLEASE CONTACT LISA ALEXANDER
(EXT. 4042 OR
LALEXANDER@TRENDSINTERNATIONAL.COM)
OR CAROL KILGORE (EXT. 4007 OR
CKILGORE@TRENDSINTERNATIONAL.COM)**

Electronic Deposit Authorization Form

Important! Please read and sign before completing and submitting.

I hereby authorize Trends International, LLC hereinafter "Company" to initiate credit entries for sums to and payable to me to my checking, savings or other account(s) indicated below; and, the Financial Institution(s) named below, hereafter called "Depositories", to credit the same to such accounts. I also authorize Company to initiate debits for sums due to the Company for erroneous deposit or deposits at the Depository (ies).

This authorization is to remain in full force and effect until Company has received written notice from me of its termination in such time and in such manner as to afford Company reasonable opportunity to act on it or until such time as Company terminates this agreement.

Employee Name: _____ Social Security #: _____ - _____ - _____

Employee Signature: _____ Date: _____

REQUIRED – ATTACH A VOIDED CHECK FOR EACH CHECKING AND/OR SAVINGS ACCOUNT LISTED (NO DEPOSIT SLIPS WILL BE ACCEPTED).

Account Information

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form.

Be sure to indicate checking or savings, along with amount or percent to be deposited into each account.

1. Bank Name/City/State: _____

Routing/Transit #: _____ Account Number: _____

Checking Savings I wish to deposit: \$_____.____ Or %_____ or Entire Net amount

2. Bank Name/City/State: _____

Routing/Transit #: _____ Account Number: _____

Checking Savings I wish to deposit: \$_____.____ Or %_____ or Entire Net amount

3. Bank Name/City/State: _____

Routing/Transit #: _____ Account Number: _____

Checking Savings I wish to deposit: \$_____.____ Or %_____ or Entire Net amount

Our payroll service charges Trends International, LLC \$15 for direct deposits that are rejected due to the inability to deposit your funds. Some of those reasons might be a cancelled account or your bank being bought out by another bank and their routing number changing. For these cases a new direct deposit form should have been submitted to the Payroll Department as soon as you knew of the change. Change forms are on the Trends website.

The \$15 will be charged back to you, if this occurs, on the next payroll date.

QP/401(k) Designation of Beneficiary

This form is used by plan participants to select primary and contingent beneficiary(ies).

PARTICIPANT INFORMATION		Social Security Number _____ First Name _____ Last Name _____ Address _____ City _____ State _____ Zip _____
CURRENT MARITAL STATUS		<input type="checkbox"/> I am Not Married – I understand that if I become married in the future, my spouse will be my Primary Beneficiary unless I complete a new <i>Designation of Beneficiary</i> form and my spouse consents to my designation. <input type="checkbox"/> I am Married – I understand that my spouse will be my Primary Beneficiary. However, I understand I may designate a Primary Beneficiary other than my spouse on the space below if my spouse signs the section below entitled “Consent of Spouse.”
DESIGNATION OF BENEFICIARY(IES)		The following individual(s) shall be my beneficiary(ies). <i>Please check Primary or Contingent for each individual beneficiary.</i> If neither is checked, the individual will be deemed to be a primary beneficiary. If any primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro rata basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my Qualified Plan balance.
Primary <input type="checkbox"/>	Contingent <input type="checkbox"/>	Beneficiary Name _____ Address _____ Social Security Number _____ Date of Birth _____ Relationship _____ Share _____ %
Primary <input type="checkbox"/>	Contingent <input type="checkbox"/>	Beneficiary Name _____ Address _____ Social Security Number _____ Date of Birth _____ Relationship _____ Share _____ %
Primary <input type="checkbox"/>	Contingent <input type="checkbox"/>	Beneficiary Name _____ Address _____ Social Security Number _____ Date of Birth _____ Relationship _____ Share _____ %
Primary <input type="checkbox"/>	Contingent <input type="checkbox"/>	Beneficiary Name _____ Address _____ Social Security Number _____ Date of Birth _____ Relationship _____ Share _____ %
CONSENT OF SPOUSE		I am the spouse of the participant named above. I hereby consent to the above designation of beneficiary. I understand that if anyone other than me is designated as Primary Beneficiary on this form, I am waiving any rights I may have to receive benefits under the plan when my spouse dies. Participant's Spouse Signature _____ Date _____ The signature of the spouse must be witnessed by a plan representative or Notary Public. Plan Representative/Notary Public _____ Date _____
AUTHORIZATION		Participant Signature _____ Date _____ Witness _____ Date _____
Plan Administrator Use Only NOTE: This form is for your files. Please do not forward this form to Ascensus.		

TRENDS INTERNATIONAL, LLC 401(K) PLAN

Change of Address

Enrollment Form

John J Doe
423-45-8789
Location: 9111320
Plan ID: 144955

NAME: _____
ADDRESS: _____

Contribution Selection

____ I wish to contribute _____ % of my compensation to the TRENDS INTERNATIONAL, LLC 401(K) PLAN (Enter a whole number between 1% - 90%)

Investment Election

Please indicate the percentage you would like to invest into the following funds. You must divide your investment in 1% multiples and your total must equal 100%. If you are unsure where to invest, examples of investment mixes are on page 6. Or, if you would like more information on these funds, please review the fund fact sheet and prospectuses provided by the Financial Advisor.

Fund Options	Percent of Contribution to Invest in Each Fund (Use whole numbers only.)	Fund Options	Percent of Contribution to Invest in Each Fund (Use whole numbers only.)
Invesco Stable Value Retirement Fd CL 5	_____ %	Oppenheimer Main St Small & Mid-Cap A	_____ %
BlackRock Global Allocation Fund A	_____ %	Blackrock Global Dynamic Equity A	_____ %
MFS Value Fund A	_____ %	Franklin Total Return Fund A	_____ %
Goldman Sachs Mid Cap Value Fund A	_____ %	Oppenheimer Global Strategic Income A	_____ %
BlackRock Mid-Cap Value Equity Port A	_____ %	PIMCO Real Return Fund A	_____ %
Prudential Jennison MidCap Gr A	_____ %	Victory Diversified Stock A	_____ %
Thornburg International Value R4	_____ %	Mainstay Large Cap Growth Fund Class R2	_____ %
GoalManager SM	_____ %	Select one only:	
		<input type="checkbox"/> CONSERVATIVE PORTFOLIO MODEL <input type="checkbox"/> CONSERVATIVE TO MODERATE <input type="checkbox"/> MODERATE PORTFOLIO MODEL <input type="checkbox"/> MODERATE TO AGGRESSIVE <input type="checkbox"/> AGGRESSIVE PORTFOLIO MODEL	
Total 100%			

Remember your election percentages must total 100%

If you do not choose investments for your savings, your contributions will be invested in the **Invesco Stable Value Retirement Fd CL 5 (100%)**.

Authorization

____ Yes, I hereby authorize the payroll deduction. Signature: _____ Date: _____

____ No, I do not wish to contribute.* Signature: _____ Date: _____

Plan Administrator Signature: _____ Date: _____

* Even if you have chosen not to contribute at this time, you must still return this form to your Plan Administrator so they know that they offered you this benefit and you decided not to participate.

Please return this form to your Plan Administrator. You should also make a copy for your own records.

Enrollment Application
Group size 51+ eligible employees



INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer. Anthem's Primary Care Physician (PCP) listings for HMO/POS plans can be obtained through www.anthem.com

TRENDS INTERNATIONAL

COMPLETE AREAS HIGHLIGHTED

SECTION 1: EMPLOYER/GROUP USE - Required

Employer name TRENDS INTERNATIONAL		Employer address 5188 W. 74TH ST, INDIANAPOLIS, IN 46268		
Group no. 00084333	Sub-group no./ Life division no. 0000	Requested effective date 0 1 0 1 2 0 1 5	Life classification	Employee no./Dept. name

SECTION 2: REASON FOR APPLICATION - Required

<input type="checkbox"/> New enrollment	<input type="checkbox"/> COBRA	<input type="checkbox"/> New hire	<input type="checkbox"/> Add dependent (Fill in Section 3)
<input checked="" type="checkbox"/> Annual open enrollment (N/A to Life)	Qualifying event _____ event date _____	<input type="checkbox"/> Rehire date _____	
<input type="checkbox"/> Waiver (To decline ALL coverage skip to Section 12)			

SECTION 3: STATUS CHANGE/EVENT - Required, if you checked "Add dependent" option in Section 2.

Event date 0 1 0 1 2 0 1 5	<input type="checkbox"/> Marriage	<input type="checkbox"/> Adoption (Attach legal documentation)	<input type="checkbox"/> Loss of coverage (reason) _____	<input type="checkbox"/> Termed employment
	<input type="checkbox"/> Birth	<input type="checkbox"/> Legal guardianship (Attach legal documentation)	<input type="checkbox"/> Other _____	

SECTION 4: PLAN/TYPE OF COVERAGE - Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 12.

Medical If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.	Type of coverage HSA Plan #1 Deductibles: <input type="checkbox"/> 2,000/4,000 HSA Plan #2 <input type="checkbox"/> 3,000/6,000	Employee only Employee+spouse (DP) Employee+child(ren) Family coverage No coverage
---	--	---

If multiple Medical Plans are available, write plan number:

*Anthem will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your Employer.

Dental To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.	Vision	Life
<input type="checkbox"/> PPO _____ <input type="checkbox"/> DentaCare (HMO) <input type="checkbox"/> Dental Blue® 100/200/300 <input checked="" type="checkbox"/> Dental Blue® 100	Type of coverage <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> No coverage	Type of coverage <input type="checkbox"/> Employee only <input type="checkbox"/> Employee+child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage
		<input checked="" type="checkbox"/> Life (Fill in Section 7)

SECTION 5: EMPLOYEE INFORMATION - Required

Last name	First name	M.I.	Date of birth	Age	Social security no. (required)
Sex <input type="checkbox"/> M <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> F <input type="checkbox"/> Divorced	Height	Weight	Home phone	Business phone	Email address
Address		City	State	ZIP code	County
Retired <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation	Full-time hire date 40	Hours working per week Income reported by <input checked="" type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other
Complete Primary Care Physician (PCP) Information for HMO or POS plans only.				Anthem PCP name and address	
				Anthem PCP ID no.	New patient <input type="checkbox"/> Yes <input type="checkbox"/> No

*****ATTACH ADDITIONAL PAGES AS NEEDED TO LIST DEPENDENTS FOR**

SECTION 6.

Employee name _____

Social security no. _____

SECTION 6: FAMILY INFORMATION – Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 10, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Spouse/Domestic Partner	Last name _____	First name _____	M.I. _____	Social security no. (required) _____			
	Date of birth _____	Height _____	Weight _____	Sex _____ <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Currently hospitalized or disabled _____ (If yes, give reason) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
If spouse/DP address is different than employee, please provide full address _____							
Anthem PCP name and address (for HMO or POS plans only) _____					Anthem PCP ID no. _____	New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent	Last name _____	First name _____	M.I. _____	Social security no. _____	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date of birth _____	Height _____	Weight _____	Sex _____ <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee _____ <input type="checkbox"/> Child <input type="checkbox"/> Other	Currently hospitalized or disabled _____ (If yes, give reason) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Court ordered health care coverage <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach legal documentation)					If dependent address is different than employee, please provide full address _____		
Anthem PCP name and address (for HMO or POS plans only) _____					Anthem PCP ID no. _____	New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent	Last name _____	First name _____	M.I. _____	Social security no. _____	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date of birth _____	Height _____	Weight _____	Sex _____ <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to employee _____ <input type="checkbox"/> Child <input type="checkbox"/> Other	Currently hospitalized or disabled _____ (If yes, give reason) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Court ordered health care coverage <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach legal documentation)					If dependent address is different than employee, please provide full address _____		
Anthem PCP name and address (for HMO or POS plans only) _____					Anthem PCP ID no. _____	New patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 7: LIFE AND DISABILITY INSURANCE - Required, if this type of coverage was selected in Section 4.

Current Income \$ _____	<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	<input type="checkbox"/> Life Class	
<input type="checkbox"/> Basic Life	<input type="checkbox"/> Optional Life _____ x Annual Earnings _____	<input type="checkbox"/> Basic AD&D	<input type="checkbox"/> Short-Term Disability _____
<input type="checkbox"/> Dependent Life	OR \$ _____	<input type="checkbox"/> Optional AD&D	<input type="checkbox"/> Long-Term Disability _____

Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.

Short-Term Disability _____ % Long-Term Disability _____ % Basic Life

Primary beneficiary

Last name _____	First name _____	M.I. _____	Social security no. _____	Relationship to employee _____	Age _____
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Contingent beneficiary

Last name _____	First name _____	M.I. _____	Social security no. _____	Relationship to employee _____	Age _____
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SECTION 8: OTHER HEALTH COVERAGE - Required

Do you and/or your dependents have other health coverage? Yes No If yes, complete below.

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company		Policy/certificate no. _____	Effective date _____
--	--	------------------------------	----------------------

Policy/certificate holder name _____	Social security no. _____	Date of birth _____	Relationship to employee _____
--------------------------------------	---------------------------	---------------------	--------------------------------

Are you and/or your dependents enrolled in Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below.			
---	--	--	--

Enrollee name _____	Medicare/Medicaid ID no. _____	Medicare Part A effective date _____	Medicare Part B effective date _____	ESRD onset date _____
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Enrollee name _____	Medicare/Medicaid ID no. _____	Medicare Part A effective date _____	Medicare Part B effective date _____	ESRD onset date _____
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Medicare Part D ID no. _____	Medicare Part D Carrier _____	Medicare Part D effective date _____	Medicare Part D term date _____
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Reason for Medicare entitlement: Age Disability ESRD & Disability End Stage Renal Disease (ESRD)

Employee name _____

Social security no. _____

SECTION 9: PRIOR HEALTH COVERAGE - RequiredHave you and/or your dependents had prior health coverage? Yes No If yes, complete below.

Have you been covered by Anthem within the past two (2) years <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy/certificate no.
---	------------------------

Group name/ID no.	Date policy in effect	Date policy termed
-------------------	-----------------------	--------------------

Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

List prior carrier(s)	Date policy in effect	Date policy termed
-----------------------	-----------------------	--------------------

Please check the type of prior coverage

<input type="checkbox"/> Employee	<input type="checkbox"/> Employee+Spouse/DP	<input type="checkbox"/> Employee+Child(ren)	<input type="checkbox"/> Employee+Spouse/DP+Child(ren)
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Termination reason:

<input type="checkbox"/> Divorce/legal separation	<input type="checkbox"/> Employment terminated	<input type="checkbox"/> Employer/group contribution ceased	<input type="checkbox"/> Other
<input type="checkbox"/> Death of spouse/DP	<input type="checkbox"/> COBRA coverage exhausted	<input type="checkbox"/> Group plan terminated	

SECTION 10: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline to this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage. I also understand that I may not be covered for pre-existing conditions.
5. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Thank you for choosing Anthem Blue Cross and Blue Shield.

SECTION 11: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 10 carefully before signing.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature _____

X

Date _____

COMPLETE THIS PAGE ONLY IF WAIVING COVERAGE

Employee name _____

Social security no. _____

SECTION 12: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
<input type="checkbox"/> Medical	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Dental	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Vision	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> Life	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	Certificate/policy no. or Carrier name and ID no.
<input type="checkbox"/> All	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)		<input type="checkbox"/> Anthem <input type="checkbox"/> Other carrier <input type="checkbox"/> No coverage	

Check all that apply:

I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his or her 19th birthday. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for coverage in the future, I may be required to provide evidence of insurability at my expense.

Please check if any of the following apply:

- I am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).
- My dependents are covered or will be covered under another plan that is not sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).
- Other: _____

SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.

Employee signature _____

X

Date _____

****IF WAIVING COVERAGE, PLEASE LIST ALL FAMILY MEMBERS THAT YOU ARE WAIVING. IF FAMILY MEMBERS ARE NOT LISTED ABOVE, AND YOU HAVE A QUALIFYING EVENT OUTSIDE OF OPEN ENROLLMENT, THEY WILL NOT BE ELIGIBLE FOR INSURANCE.**



Underwritten by
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

CHANGE Supplemental Life

Term Life and AD&D Insurance Enrollment Form

FOR EMPLOYEE TO COMPLETE

GROUP PLAN #: 587672 DIVISION:

EMPLOYEE NAME (last name, first, middle initial)	EMPLOYER NAME TRENDS INTERNATIONAL		
EMPLOYEE ADDRESS (street, city, state, zip code)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF EMPLOYMENT	HOURS WORKED PER WEEK	OCCUPATION
ANNUAL EARNINGS	HAVE YOU USED ANY TOBACCO PRODUCTS IN THE LAST 12 MONTHS? <input type="checkbox"/> Yes <input type="checkbox"/> No		

COVERAGE ELECTIONS

AMOUNT OF COVERAGE SELECTED FOR:

Life You: \$ _____ Your Spouse: \$ _____ Each Child: \$ _____
AD&D \$ _____ \$ _____ \$ _____

NOTE: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date UnumProvident approves your Evidence of Insurability form. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. This applies to Life coverage only.

Spouse Information (complete only if spouse coverage is selected)

NAME:	SOCIAL SECURITY #:	DATE OF BIRTH:
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Beneficiary Information

NAME (last name, first, middle initial):	RELATION TO YOU:	BENEFIT %:
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IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:

--	--	--

REQUEST FOR SIGNATURE Please read the back of this form carefully before signing below.

CERTIFICATION: I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request. I have read and understand the INFORMATION ABOUT DELAYED EFFECTIVE DATES and EXCLUSIONS on the reverse side of this enrollment form. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature

Date

Work Phone

Home Phone



2015

HEALTH SAVINGS ACCOUNT

EMPLOYEE CONTRIBUTIONS ENROLLMENT/CHANGE FORM

2015 IRS MAXIMUM – Individual Coverage \$3,350 Family (one or more) Coverage \$6,650

EMPLOYEE NAME: _____

CONTRIBUTION SEMI-MONTHLY (24 PAY PERIODS) _____

EFFECTIVE DATE: _____

EMPLOYEE SIGNATURE: _____

DATE SIGNED: _____

This section for Human Resource Department Only.

Checked to make sure total for year is not over IRS maximum (Employee + Employer Contributions): _____

Update Automated Payroll Services: _____

Updated Excel Spreadsheet to Credit Union: _____

File Insurance File: _____

Human Resource Representative Signature

Date

Trends International, LLC. - Account #028-3008

FLEXIBLE BENEFITS ELECTION/CHANGE FORM

I. PERSONAL INFORMATION

Employee Name: _____

Social Security Number: _____

Address: _____

II. PURPOSE OF FORM

- Election Revision due to change in family status (check one):
 Marriage or Divorce
 Commencement of Spouse's Employment
 Gaining a Dependent
 Termination of Spouse's Employment
 Losing a Dependent

III. INSURANCE PREMIUM REDIRECTION ACCOUNT

Your share of the premium for the Trends International, Inc. Group Health Plan can be made on a pre-tax basis. This means your contribution amount will be taken from your gross pay before federal and state taxes are applied. This will lower your taxable income.

Please indicate if you want your insurance premium to be processed on a pre-tax basis:

Yes No N/A (i.e., you do not participate or plan to participate in the Health Plan)

IV. HEALTH CARE REIMBURSEMENT ACCOUNT

If you choose to participate in the Health Care Flexible Spending Account, enter the amount you want to redirect each pay period (subject to the minimum and maximum of the plan).

\$ _____
Per Pay Period

V. DEPENDENT CARE REIMBURSEMENT ACCOUNT

If you choose to participate in the Dependent Care Flexible Spending Account, enter the amount you want to redirect each pay period (subject to the minimum and maximum of the plan).

\$ _____
Per Pay Period

VI. SIGNATURE

By signing this form, I authorize my employer to redirect (reduce) my gross pay by the indicated amounts. I understand that:

- I cannot change or suspend my election until the next open election period unless my family status changes.
- I cannot transfer money between the reimbursement accounts.
- Any money in my account(s) not used to pay expenses incurred during the plan year will be forfeited.
- The redirections I have elected are made in accordance with the plan document and the provisions of the Internal Revenue Code Section 125, and will be taken out in equal installments throughout the year.
- This is an annual election form and needs to be filled out each year, failure to complete a new form at the beginning of each year means I will no longer be a Plan participant.

Signature: _____ Date: _____

Questions regarding the administration of your reimbursement accounts (if elected) should be directed to the Benefits Office.

PLEASE READ!

Note: the following pages must be signed and returned whether you want to participate in the flexible spending plan or not.

The attached documents relate to the Trends International Compensation Redirection Plan. Included in these documents is detailed information about how this Plan works and how it can save you money. Also, included are the necessary enrollment forms and worksheets to help you decide the appropriate amounts for you.

It is very important if you participate in the company's health plan that you complete the enrollment form so that we can take your insurance premium deduction out of your paycheck on a pre-tax basis.

Note: if you are not eligible for health insurance plan until after January 1 the total number of pay periods will vary. For example, if you are eligible for the health plan on February 1st you will receive only 22 eligible pays during the year. Therefore, you should use 22 pay periods when calculating your election amount.

If you have any questions, please contact Carol at 317-388-4007.

**TRENDS INTERNATIONAL, LLC SALARY REDUCTION PLAN
SUMMARY PLAN DESCRIPTION ACKNOWLEDGEMENT FORM**

I [REDACTED] HAVE RECEIVED A COPY OF THE
SUMMARY PLAN DESCRIPTION FOR THE TRENDS
INTERNATIONAL, LLC SALARY REDUCTION PLAN.

[REDACTED]
EMPLOYEE SIGNATURE

[REDACTED]
DATE

[REDACTED]
SENIOR HR MANAGER

[REDACTED]
DATE

**Trends International, LLC Salary Reduction Plan
Election Form and Compensation Redirection Agreement**

FLEX SPENDING FOR HEALTH, RX, DENTAL, VISION, AND CHILD CARE.

Employee Name: _____ Social Security #: _____

Employee Address City, State, and Zip:_____

Plan Year January 1, 2015 thru December 31, 2015

As an eligible participant in the Cafeteria 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. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the plan year (or during such portion of the year as remains after the date of this agreement).

ELECTION OF FSA LIMITED HEALTH CARE REIMBURSEMENTS

(DENTAL & VISION expenses only) – 24 PAY PERIODS A YEAR

I elect FSA health care reimbursements for the plan year. Amount of compensation redirection:

\$ _____ per each pay period x _____ pays which is a total of \$ _____ for the plan year (cannot exceed the maximum amount allowed under the plan). **THE CURRENT LIMIT IS \$2,000 PER YEAR.**

I understand that:

- Reimbursement will be available only for "qualifying health care expenses" as described in 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 non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.

ELECTION OF FSA HEALTH CARE REIMBURSEMENTS

For those who are NOT on a High Deductible Health Insurance Plan

This is for employees who do not have medical insurance through Trends.

(HEALTH, PRESCRIPTION, DENTAL, VISION expenses) – 24 PAY PERIODS A YEAR

I elect FSA health care reimbursements for the plan year. Amount of compensation redirection:

\$ _____ per each pay period x _____ pays which is a total of \$ _____ for the plan year (cannot exceed the maximum amount allowed under the plan). THE CURRENT LIMIT IS \$2,000 PER YEAR.

I understand that:

- Reimbursement will be available only for "qualifying health care expenses" as described in 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 non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.

RESTRICTIONS ON PAYMENT FOR OVER-THE-COUNTER DRUGS

New IRS regulations provide that, beginning after December 31st, 2010, expenses incurred for a medicine or drug will be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin. Thus, under new Section 106 (f), expenses incurred for medicines or drugs may be paid or reimbursed by an employer-provided plan, including FSA, only if the medicine or drug:

- Requires a prescription
- Is available without a prescription (an over-the-counter medicine or drug) and the individual obtains a prescription, or
- Is insulin

ELECTION OF DEPENDENT CARE REIMBURSEMENT

24 PAY PERIODS A YEAR

I elect FSA dependent care reimbursement for the plan year. Amount of compensation Redirection:

\$ _____ per each pay period x _____ pays which is equal to a total of \$ _____ for the plan year

The maximum cannot exceed the lesser of the amount allowed under the plan or \$5,000 if married filing joint tax return or \$2,500 if filing separate tax return by a married individual.

I understand that:

- Reimbursement will be available only for "qualifying dependent care expenses" as described in 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 non-qualifying expense, up to the amount of additional tax actually owed by me.
- This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to twice the amount of that redirection.

ELECTION OF INSURED BENEFITS – BOTH HEALTH SAVINGS PLAN 1 AND HEALTH SAVINGS PLAN 2

**MUST BE COMPLETED IF ENROLLING IN HEALTH, RX, DENTAL, VISION (FOR
PREMIUM ONLY PLAN (POP) PORTION FOR SECTION 125)**

On the appropriate benefit enrollment form(s), I have enrolled for certain group insurance coverage as indicated below. Please withhold from my pay the amount as outlined by provider for such coverage.

**THIS IS FOR THE EMPLOYEE PREMIUMS TO PAY FOR THE ENROLLMENT IN TRENDS
INSURANCE PLAN.**

RATES SEMI-HEALTH SAVINGS PLAN 1 – HEALTH/PRESCRIPTION

EMPLOYEE ONLY	104.43
EMPLOYEE + CHILD(REN)	184.85
EMPLOYEE + SPOUSE	250.64
FAMILY	319.48

RATES SEMI-MONTHLY HEALTH SAVINGS PLAN 1 – DENTAL/VISION PLAN

EMPLOYEE ONLY	5.08
EMPLOYEE + CHILD(REN)	10.41
EMPLOYEE + SPOUSE	10.16
FAMILY	16.60

RATES SEMI-MONTHLY HEALTH SAVINGS PLAN 2 – HEALTH/PRESCRIPTION

EMPLOYEE ONLY	46.71
EMPLOYEE + CHILD(REN)	82.67
EMPLOYEE + SPOUSE	112.10
FAMILY	142.93

RATES SEMI-MONTHLY HEALTH SAVINGS PLAN 2 – DENTAL/VISION

EMPLOYEE ONLY	5.08
EMPLOYEE + CHILD(REN)	10.41
EMPLOYEE + SPOUSE	10.16
FAMILY	16.60

COVERAGE	PREMIUM PER PAY PERIOD –
<u>INPUT AMOUNTS LISTED ABOVE THAT PERTAIN TO YOUR TYPE OF COVERAGE. i.e. enrolling in HSA PLAN 1 Plan: \$</u>	
<u>health/prescription and \$</u>	
<u>dental/vision</u>	
<u>Enrolling in HSA PLAN 2 Employee Only: \$</u>	
<u>health/prescription and \$</u>	
<u>dental/vision.</u>	

group health/prescription insurance \$ _____
 group dental/vision insurance \$ _____

I understand that:

- If my required contributions for the elected benefits are increased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase (or decrease).
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit election 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 either continue my benefit coverage and amount of compensation redirection then in effect for the new plan year, or to have elected not to participate

for the upcoming plan year, as set forth in the Summary Plan Description.

DESIGNATION OF BENEFICIARY

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek the payment of benefits under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

Name: _____

Address: _____

Relationship: _____

OTHER TERMS AND CONDITIONS

I understand that:

- I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The redirection of my cash compensation under this agreement shall be in addition to any redirection under other agreements or benefit plans.
- The amount of my compensation redirection will be credited to an insurance, health care reimbursement, and/or dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed, up to the amount which I have elected to redirect to the Cafeteria Plan, for the applicable expenses incurred during the year.
- Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year.
- My Social Security benefits may be reduced as a result of my election.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S SALARY REDUCTION PLAN, HEALTH CARE REIMBURSEMENT PLAN AND/OR DEPENDENT CARE ASSISTANCE 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 REDIRECTION AGREEMENT RELATING TO SUCH PLAN(S).

PRE-TAX EMPLOYEE PREMIUMS ONLY

Employee's Signature _____ Date: _____

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

By: _____ Date: _____

WAIVER OF PARTICIPATION – FLEX SPENDING ONLY

This waiver will acknowledge that I have been informed of the terms of the above referenced Plan. Even though I am eligible to participate in such Plan, I hereby elect not to participate. I understand that this waiver will remain in effect for the remainder of the plan year for which this election is effective, but that I may again decide to participate in later plan years by making an election to participate during the election period prior to each plan year.

This waiver is effective for the plan year running from _____, 20 ____ to _____, 20 ____.

Employee's Signature: _____ Date: _____

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

By: _____ Date: _____

COMPENSATION REDIRECTION WORKSHEET

INSURANCE PREMIUM REDIRECTION

Monthly premiums for accident & health insurance policies allowed by the Plan (May not include cost of health insurance provided by spouse's employer)	\$ _____ (A)
Annual insurance cost (A x 12)	\$ _____ (B)
Number of pay periods	\$ _____ (C)
Total premium redirection per pay period	(B divided by C)

HEALTH CARE REDIRECTION

This worksheet is to help you estimate your annual medical costs which may not be reimbursed by insurance. This list is not intended to be comprehensive, but it contains some of the more common medical expenses. Please review the additional qualifying health care expenses. List all costs that are NOT REIMBURSED BY INSURANCE.

<u>Qualifying Expense</u>	<u>Estimated Annual Expenses</u>
Medical doctors' fees	\$ _____
Annual physical examinations	\$ _____
Dental examinations	\$ _____
Eye examinations	\$ _____
Eyeglasses	\$ _____
Contact lenses & supplies	\$ _____
Prescription drugs (including birth control not covered by insurance)	\$ _____
X-rays	\$ _____
Lab fees	\$ _____
Hospital services	\$ _____
Chiropractors	\$ _____
Hearing aids & batteries	\$ _____
Surgery	\$ _____
Ambulance service	\$ _____
Nursing home costs	\$ _____
False teeth	\$ _____
Psychiatrists	\$ _____
Psychologists	\$ _____
Acupuncturists	\$ _____
Orthodontia	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
Total estimated annual expenses (MUST be limited to maximum amount allowed under the plan)	\$ _____ (D)
Number of pay periods (from date of election to end of plan year)	\$ _____ (E)
Total health care redirection per pay period	(D divided by E)

TRENDS INTERNATIONAL, LLC FLEXIBLE SPENDING ACCOUNT PLAN
SUMMARY PLAN DESCRIPTION

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XI
SUMMARY

TRENDS INTERNATIONAL, LLC FLEXIBLE SPENDING ACCOUNT PLAN

INTRODUCTION

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I ELIGIBILITY

1. When can I become a participant in the Plan?

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

2. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

You can join the Plan on the same day you can enter our group medical plan.

4. Are there any employees who are not eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are members of the Limited Liability Company.

5. What must I do to enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

**II
OPERATION**

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

**III
CONTRIBUTIONS**

1. How much of my pay may the Employer redirect?

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

4. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance or if you decide to participate in the Health Savings Account.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

Any change permitted under this Section must be requested within 30 days of the date the change in status occurs or such other time as allowed under the corresponding benefit.

6. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

IV BENEFITS

1. What benefits are offered under the Plan?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year.

2. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. If you participate in a Health Savings Account, the Health Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket expenses incurred by you and your dependents.

If you are an HSA participant, drug costs, including insulin, may be reimbursed if they are considered for. Beginning January 1, 2011, you may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the

cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is \$2,000. In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for 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.

3. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- (a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- (b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- (c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

4. Premium Expense Account

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our insured group medical plan.
- Dental insurance premiums.
- Vision insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

5. May I direct Plan contributions to my Health Savings Account?

Yes. Any monies that you do not apply toward available benefits can be contributed to your Health Savings Account, which enables you to pay for expenses which are not covered by

our insured medical plan and save taxes at the same time. Please see your Plan Administrator for further details.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited, except for amounts contributed to your Health Savings Account. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

- (a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- (b) You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 90 days after the end of the Plan Year in which termination occurs.
- (c) Your Health Savings Account amounts will remain yours even after your termination of employment.
- (d) For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

7. Qualified Reservist Distributions

If you are a member of a reserve unit and if you are ordered or called to active duty, then you may request a Qualified Reservist Distribution (QRD). A Qualified Reservist Distribution is a distribution of all or a portion of the amounts remaining in your Health Flexible Spending Account. You can only request this distribution if you are called to active duty for a period of 180 days or more or for an indefinite period. The distribution must be made during the period beginning on the date of the call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of the call.

You can receive the entire amount you elected for the Plan Year, minus any reimbursements you have already received (or are in process). The amount you request may be

adjusted if needed to conform with your actual account balance. You must request the QRD before the last day of the Plan Year. You can only request 1 QRDs for a Plan Year.

VI HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Trends International, LLC Flexible Spending Account Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on January 1, 2009. Your Plan was originally effective on January 1, 2002.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address, and identification number are:

Trends International, LLC
5188 West 74th Street
Indianapolis, Indiana 46268
26-0087431

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Administrator.

Other Employers who have adopted the provisions of the Plan are:

WallDaddy, LLC
5188 W. 74th Street
Indianapolis, IN 46268
20-5415290

Total Retail Services, Inc.
5188 W. 74th Street
Indianapolis, IN 46268
61-1569500

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Trends International, LLC
5188 West 74th Street
Indianapolis, Indiana 46268
317-388-4077

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Trends International, LLC
5188 West 74th Street
Indianapolis, Indiana 46268

5. Type of Administration

The type of Administration is Contract Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Trends International, LLC
5188 West 74th Street
Indianapolis, Indiana 46268

IX ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

- (a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- (b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;
- (c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and
- (d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial;
- (b) Reference to the specific Plan provisions on which the denial was based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;
- (e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- (f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

X CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- (a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (a) The death of a covered Employee.
- (b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (d) A covered Employee's enrollment in any part of the Medicare program.
- (e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

4. What factors should be considered when determining to elect COBRA continuation coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You

have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Recent changes in the law increased this assistance temporarily to 80%, and temporarily extended the period of COBRA continuation coverage for eligible individuals. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.dol.gov/tradeact.

7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (a) the end of employment or reduction of hours of employment,

- (b) death of the employee,
- (c) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (d) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Trends International, LLC
5188 West 74th Street
Indianapolis, Indiana 46268

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date it happened**.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives **timely notice** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

9. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (a) The last day of the applicable maximum coverage period.
- (b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (e) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (f) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

- (2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This

notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

13. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

14. Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

16. What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

17. Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

18. How is my participation in the Health Flexible Spending Account affected?

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

**XI
SUMMARY**

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Trends®

International

HEALTH SAVINGS ACCOUNT

FINANCIAL CENTER FEDERAL CREDIT UNION

IF YOU ARE ENROLLED IN THE HEALTH SAVINGS ACCOUNT, DO YOU WANT TO TERMINATE YOUR SPOUSE FROM THE ACCOUNT WITH THE FINANCIAL CENTER FEDERAL CREDIT UNION.

IF SO, YOU WILL NEED TO CONTACT THE CREDIT UNION AT www.fcfcu.com OR CALL 317-916-6151.