# GIGA, INC. CAFETERIA PLAN
# FLEXIBLE SPENDING ACCOUNT ELECTION
## PLAN YEAR 1/1/2017 – 12/31/2017

**Name**_____ **Soc Sec No**_____-____-_____

**Address**_____**City**_____**State**_____**Zip**_____

**E-mail**_____ **Daytime Phone**____-____-_____

**Pay Period(# Pay checks): (CIRCLE ONE) Weekly(52) Bi-weekly(26) Semi-Monthly-(24) Monthly(12)**

| Flexible Spending Accounts | Amount per Pay Check | | # of Pay Checks | | Annual Amount |
|---|---|---|---|---|---|
| **Dependent Daycare FSA** | **$**_____ | **X** | _____ | **=** | **$**_____ **($5,000 Maximum)** |
| **Health FSA** | **$**_____ | **X** | _____ | **=** | **$**_____ **($2550. Max)** |

I understand that:

- For the Health FSA, reimbursements will be available only for "qualifying medical care expenses" for yourself, your spouse and dependents (including children up to age 26). Generally, "qualifying medical care expenses" are those medical, dental and/or vision expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation) or otherwise allowed by law. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.
- I cannot claim expenses that are reimbursable under any other plan, including another employer's plan that covers me or any of my eligible dependents.
- Claims must be submitted within 90. days after the end of the Plan Year.
- If you terminate employment, claims must be submitted within 90. days after the date of your termination, subject to the conditions below.
- If I cease my employment with the Employer, my participation in the Health FSA will cease. No further contributions will be made to the Health Flexible Spending Account on my behalf, although I may submit claims for expenses that were incurred during this plan year and no later than my last day of employment.
- If I cease my employment with the Employer, my participation in the Dependent Care FSA will cease.
- I cannot seek reimbursement from the Health FSA for a medical expense which I intend on taking as a deduction or credit on my tax return.
- For the Dependent Care FSA, reimbursement will be available only for "qualifying dependent care expenses" as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense
- For the Dependent Care FSA, I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred. I agree to provide the Administrator with the name, address, and the taxpayer identification number of the service provider.
- For the Dependent Care FSA, I will only be reimbursed for amounts up to the balance in my account at the time of my request.
- I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this Dependent Care FSA.

**OTHER TERMS AND CONDITIONS**

I understand that:

- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the Plan Year unless I have a change in status and my change in election is consistent with such change.
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.
- Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later Plan Year.
- This agreement will automatically terminate if the Plan is terminated, discontinued, or if I cease to receive compensation from the Company.
- My employer cannot be responsible for any tax liabilities which may subsequently occur as a result of my Cafeteria Plan participation.
- This is a pay reduction plan, and may result in reduced Social Security Benefits in the future.

Prior to the first day of each Plan Year I will be offered the opportunity to elect a Flexible Spending Account for the new Plan Year. If I do not submit a completed Election Form before the first day of the new Plan Year, I will be treated as having elected not to participate in the Flexible Spending Accounts for the new Plan Year.

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

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Signature of Employee Date