GIGA, INC.
CAFETERIA PLAN - ELECTION FORM
EFFECTIVE DATE: 01/01/2016

EMPLOYEE INFORMATION

Name: _____ Soc Sec #: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Phone: _____

Pay Period: Semi-Monthly Monthly Date of Hire: _____ Dept: _____ EE #: _____

CAFETERIA PLAN ELECTION

(All full time employees must complete YES or NO, regardless of whether you participate in any insurance benefits)

☐ **YES** **I elect to have my total eligible amount reduced from my gross pay on a pre-tax basis on each pay period continuing in effect, for all future plan years unless changed or eliminated by a new election.**

INSURANCE COVERAGE TYPE	PAY PERIOD AMOUNT
HEALTH INSURANCE	$_____
DENTAL INSURANCE	$_____
SHORT-TERM DISABILITY[1]	$_____
HOSPITAL INDEMNITY	$_____
CANCER INSURANCE [2]	$_____
VISION CARE	$_____
ACCIDENT,	$_____

NOTE: I understand that I will be given the opportunity to make an new insurance premium election annually. If I do not submit a new election form, my current insurance premium election will continue.

FLEXIBLE SPENDING ACCOUNTS	CURRENT DEDUCTION	AMOUNT PER PAY PERIOD	# OF PAY PERIODS	ANNUAL AMOUNT	
DEPENDENT DAYCARE	Refer to paycheck for current year deduction	$_____	X _____	=$_____	($ 5,000 Maximum)
UNREIMBURSED MEDICAL		$_____	X _____	=$_____	($ 2,550 Maximum)

NOTE: I understand that I will have the opportunity to make a new FSA election each year. If in future Plan Years I do not make a new FSA election, then I will not be enrolled in the FSA portion of the Cafeteria Plan.

IN MAKING THESE ELECTIONS, I AGREE TO THE FOLLOWING:

- I cannot change or revoke this compensation 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), employment status, or other such events as the Plan Administrator determines will permit a change or revocation.
- This agreement will automatically terminate if the Plan is terminated, discontinued, or if I cease to receive compensation from the Company.
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- I understand that 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.

1 I understand that by electing to include my disability premiums in the Section 125 plan if I am to receive a disability benefit, the money I receive will be taxable as income.

2 I understand that by electing to include my cancer premiums in the Section 125 plan if I am to receive any cancer benefit, the money I receive may be taxable as income.

- If I do not incur enough expenses within the Plan Year or file claims for all the funds in my account by the runout period listed in the adoption agreement, the excess funds will not be returned to me.
- I understand that I cannot claim expenses that are reimburseable under any other plan, including another employer's plan that covers me or any of my eligible dependents. This agreement is subject to the terms of the Employer's Cafeteria Plan and this Election and Compensation Reduction Agreement shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to the Employer's Flexible Benefit Plan.

☐ **NO** **I do not elect to participate in the Cafeteria Plan.**

_____ _____

(Employee Signature) **(Date)**

Eligibility Requirements

Premium Waiting period: 90 day(s)	Daycare FSA Waiting period: 90 day(s)	Medical FSA Waiting period: 90 day(s)
Entry Date: 1st day of pay period following	Entry Date: 1st day of pay period following	Entry Date: 1st day of pay period following

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DIRECT DEPOSIT AUTHORIZATION FORM
FLEXIBLE SPENDING ACCOUNT REIMBURSEMENTS

I elect to have BeneTech deposit my Medical and/or Dependent Care payments into my bank account via direct deposit.

DIRECT DEPOSIT INFORMATION AND AUTHORIZATION
I authorize BeneTech Administrators, Inc. and the financial institution listed below to deposit my Flexible Spending Account reimbursements automatically to the indicated account.

Bank/ Credit Union Routing Number	State	Checking Savings (Circle One)	Account Number

(Employee authorizing direct deposits- Print Name/then sign) (Date)

(Name of Company)

ATTACH VOIDED CHECK HERE

(Please attach a VOIDED CHECK for checking account direct deposit or a deposit slip for savings account direct deposit.)

It is my responsibility to verify deposits before writing checks against these funds