

SALARY REDIRECTION AGREEMENT

EMPLOYER: CAI POLY CORPORATION
EMPLOYER TAX ID NUMBER: 9 5 - 1 6 4 8 1 8 0
AFFILIATE NAME/LOCATION: _____
AFFILIATE TAX ID NUMBER: _____
 Flex One® FSA? Yes No **CAFETERIA PLAN YEAR:** 1 / 1 / 12 - 12 / 31 / 12

(CHECK ONE) **OPEN ENROLLMENT** OR **NEWLY ELIGIBLE EMPLOYEE, ELIGIBILITY DATE:** ___ / ___ / ___
SOCIAL SECURITY NO.: _____ **DATE OF BIRTH:** ___ / ___ / ___ **PHONE:** (____) _____
NAME: (Last) _____ (First) _____ (Middle Initial) _____
STREET ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP:** _____
E-MAIL: _____

No. of Payroll Cycles in Plan Year: 26 Date of first deduction: 01 / 13 / 12 Payroll Mode: Weekly Bi-Weekly Semi-Monthly Monthly

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution and/or Flexible Spending Account(s) (FSA) election amounts will be deducted from my paycheck by my employer or Third Party Payroll Administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage and/or FSA account election amount as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to "employer-provided" non-elective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Flexible Benefits Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

Check the desired coverage(s) below. (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for any increase/decrease in premium or required contribution) except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage	X	N/A	Accident Insurance		N/A
Dental Insurance (AFLAC)		N/A	Short-Term Disability Insurance	N/A	N/A
Vision Care Insurance	N/A	N/A	Long-Term Disability Insurance	N/A	N/A
Cancer Insurance		N/A	Hospital Indemnity Insurance	N/A	N/A
Intensive Care Insurance	N/A	N/A	Personal Sickness Indemnity		N/A
Specified Health Event		N/A	Health Savings Account (HSA) §223	N/A	N/A
Group Term Life Insurance (If family, must be after-tax)	N/A	N/A	Other accident or health plan(s) under section 106 of the Internal Revenue Code	N/A	N/A
			List: <u>None</u>		

Complete the following section only if participating in a Medical or Dependent Care Reimbursement Plan:

Medical Care FSA Plan: (\$ _____ per pay period) X (26 number of deductions) = \$ _____ Annual Election
 Dependent Care FSA Plan: (\$ _____ per pay period) X (26 number of deductions) = \$ _____ Annual Election

Required acknowledgement to participate in Flexible Benefits Plans:

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Flexible Benefits Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Flexible Benefits Plan.

INITIAL

WAIVER OF PRE-TAX BENEFITS UNDER THE FLEXIBLE BENEFITS PLAN:

I elect to waive all pre-tax benefits under the Flexible Benefits Plan. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

INITIAL

EMPLOYEE SIGNATURE: _____ **DATE:** _____