Employee Payroll Agreement

(Reduction Agreement)

AMERICAN MUTUAL BENEFITS

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Instructions: Please read this agreement carefully before signing, fill out the applicable blanks and indicate the options in which you would like to participate. Sign, date and return this agreement to your Payroll/Human Resources Dept. Forward **copy** to AMB **only if** Dependent Care is selected

Employer Name	Phone Number	
Employee Name	Social Security Number	
Address	Home Phone	
City	State	Zip

My Employer (listed above) and I hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement.)

Benefit Payments

I request that the following benefits be deducted from my paycheck before taxes:

Eligible health and/or other individual or group coverage that I have enrolled in using the appropriate forms.

Other Premiums _____ $ _____

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Dependent Care Account

I elect to have $_____ **per month** set aside from my paycheck before taxes to reimburse me for eligible dependent care expenses which I incur during the plan year. Annual maximum amount of $5,000 (e.g., $5,000 ÷ 12 months = $416.66 per month.)

Name of Provider _____

Address _____ SSN/Tax I.D. _____

City _____ State _____ Zip _____

Employee Authorization - I certify that the above information is true and correct to the best of my knowledge and 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.
- The Administrator may reduce, cancel or modify this agreement in the event it is advisable in order to satisify certain provisions of the Internal Revenue Code.
- My Social Security benefits may be slightly reduced as a result of my election.
- The amounts remaining in my reimbursement accounts at the end of the year will be forfeited.
- The amount of my compensation redirection during the year will be credited to an insurance and/or dependent care account and such amount will be paid on my behalf or I will be reimbursed for the qualified expenses incurred during the year.
- I understand that my medical election (including premiums) will be continuous and automatic from Year to Year until changed by me. However, I must re-enroll for elected dependent care benefits each and every year, and my annual election will NOT automatically be carried forward into the next Plan Year.

Employee's Signature **Date**

X YES Sign Here >

I acknowledge that the available benefits have been explained to me. I have been given the opportunity to enroll in the plan and have elected not to enroll my self and/or my dependents. I understand that this election CAN NOT be changed until the next plan year anniversary.

Employee's Signature **Date**

X NO Sign Here >