CPM, Inc.

ELECTION FORM AND SALARY REDUCTION AGREEMENT

PLAN YEAR: ____________ FROM: ______________ THRU: __________

PLAN NAME: ____

EMPLOYEE NAME: ____ DATE: _________________

STREET _____________________________ CITY _______________ STATE ______ ZIP __________

SSN: ___________________________ DOB: _________________ DATE OF HIRE: _________________

- ❑ I elect NOT to participate in the Section 125 (Cafeteria) Benefits Plan. 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 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. (Sign and date at the bottom of the page.)

- ❑ In accordance with the rights under the Plan, I elect the following benefits and designate the following amounts for each benefit I have selected for the Plan Year specified above. The Employer and I agree that my cash compensation will be reduced by the amounts set forth below for each pay period for the Plan Year (or during such portion of the year as remains after the date of this agreement). (Sign and date at the bottom of the page.)

ELECTION OF BENEFITS

	PLAN	AMOUNT PER PAY PERIOD X __________ pay periods	=	ANNUAL AMOUNT
❑	Group Health Plan Premiums	$ ____________		$ ____________
❑	Unreimbursed Medical Costs	$ ____________		$ ____________
❑	Dependent Care	$ ____________		$ ____________
❑	Other (Insurance Premiums, etc)	$ ____________		$ ____________
	PLAN TOTALS	$ _____________		$ ____________

Employee Signature : ____ Date :_____________

My signature authorizes said contributions and I attest I have read the reverse side of this form.

A Health FSA (Cafeteria Plan) may reimburse a medical expense only if the participant provides a written statement from an independent third party (health insurance benefit provider) indicating the amount of such expense and the amount of that expense that has (or has not) been reimbursed.
This must be filed with your reimbursement request.

CAFETERIA BENEFITS PLAN ELECTION FORM
QUALIFYING EXPENSES ATTACHEMENT

INSURANCE BENEFITS

I understand that:

If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect that increase or decrease.

HEALTH CARE REIMBURSEMENT

I understand that:

Reimbursement will be available only for "qualifying medical care expenses." Generally, "qualifying medical care expenses" are those medical expenses normally deductible on my Federal income tax return (without regard to the percentage of adjusted gross income limitation). 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 or state income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive Compensation from the Employer which, before reduction hereunder, is at least equal to the amount of that reduction. I cannot seek reimbursement from this account for a Medical Expense, which I intend on taking as a deduction on my tax return.

ELECTION OF DEPENDENT CARE ASSISTANCE

I understand that:

Reimbursements will be available only for "qualifying dependent care expenses" pursuant to 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 medical expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold Federal or state income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax actually owed by me.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive Compensation from the Employer which, before reduction hereunder, is at least equal to twice the amount of that reduction. I cannot claim a dependent care tax credit on amounts I receive as reimbursement under the Dependent Care Assistance Program.

The Dependent Care Assistance Program, pursuant to Code Section 129 permits up to $5,000 to be excluded from the Participant's gross income ($2,500 in the case of a separate return by a married individual) if the excluded amounts are used to help pay for the care of a qualified dependent. The Participant should be aware that Code Section 21 permits a credit against tax computed on expenses of up to $2,400 is there is one qualified dependent of the taxpayer and up to $4,800 if there is more than one qualified dependent of the taxpayer. The Participant should be aware that no dependent tax credit is permitted for amounts for which reimbursement is made.

OTHER TERMS AND CONDITIONS

I understand that:

I cannot change or revoke any of my elections or this Salary Reduction Agreement at any time during the Plan Year unless I have a change in family status, (including marriage, divorce, death of Spouse or child, birth or adoption of a child, termination of employment of a Spouse).

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 provision of the Code.

The reduction in my case Compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

The amount of Compensation reduction for each pay period during the year will be credited to reimbursement accounts or used to pay premiums on insured benefits and such amount will be paid on my behalf or I will be reimbursed, up to the balance in that account, for the applicable expenses incurred during the Plan Year.

Any amounts that are not used during a Plan Year to provide benefit 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.

Prior to the first day of each Plan Year, I will be offered the opportunity to change my Benefit elections 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 not to participate for the following Plan Year.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE CAFETERIA BENEFITS PLAN DOCUMENT, AS AMENDED FROM TIME TO TIME IN EFFECT, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN.

EMPLOYEE'S SIGNATURE______________________________________ DATE:_________________

Accepted and agreed to by the Employer's Authorized Representative.
DATE: _________________ BY: ____