Rose and Kiernan, Inc.

ULSTER COUNTY
FLEXIBLE BENEFITS PLAN
Election Form and Compensation Reduction Agreement

Employee Name: ____Employee Number________________

Employee Address: ____

City, State and Zip: ____

Employee Social Security Number: _________________________________ DOB: ________________________

Flexible Spending Plan Year: **January 1 – December 31, 2010** Enrollment: **November**
My employer 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). The following tax dependents are eligible under my Flexible Benefits Plan.

Dependent Name	Date of Birth	Relationship

I. Premiums Under Certain Benefit Plans

I may be eligible for certain health, dental, and/or vision insurance coverages.

Where I have enrolled for such plan(s), my premium contributions will be paid, if any, on a pre-tax basis, unless I complete an "Election Not to Participate" form available through my employer.

II. Unreimbursed Medical Expense Account

I elect to make contributions to a medical reimbursement account for this plan year as follows:

Amount of compensation reduction: $ ____________ **per pay period**, for ___ pay periods.
***Yearly compensation reduction**:* $______________
The annual plan limit is $1,500 per participant.

Qualifying Medical Care Expenses

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your federal income tax return with certain exceptions (i.e., health insurance provided by a spouse's employer cannot be reimbursed).

III. Dependent Care Assistance Account

I elect to make contributions to a dependent care assistance account for this plan year as follows:

Amount of compensation reduction: $ ____________ **per pay period**, for ___ pay periods.
***Yearly compensation reduction**:* $______________
(Up to $5,000 or $2,500 if married filing separate tax returns)

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE EMPLOYER'S FLEXIBLE BENEFITS PLAN, MEDICAL REIMBURSEMENT PLAN, AND/OR DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME; AND SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS. I UNDERSTAND THAT I CANNOT CHANGE ANY OF MY ELECTIONS DURING THE PLAN YEAR UNLESS I HAVE A CHANGE IN FAMILY STATUS AND THAT ANY MONEY LEFT IN MY ACCOUNT(S) AT THE END OF THE PLAN YEAR WILL BE FORFEITED.

Employee's Signature ____ Date ______________

Accepted and agreed to by the employer's Authorized Representative.

By ____ Date ______________

Please mail completed form to: Business/Human Resources Department