



JR3 EDUCATION ASSOCIATES, L.P.
Section 125 Cafeteria Plan Salary Reduction Agreement

Employee Name: _____

Employee Address: _____
Street Address City State Zip Code

Social Security Number: _____ Date of Birth: _____

Date of Hire: _____ Effective Date: _____ 1st payroll deduction: _____

Plan Year: January 1 through December 31 Effective Date: _____

Email Address: _____

ELECTION OF BENEFITS

Health Care Reimbursement Plan

This account allows you to use pre-tax dollars to pay for eligible medical expenses that are not covered by any health care plan under which you, your spouse, or your dependents are covered. Your election may not exceed \$5,000 per plan year.

I elect Health Care Reimbursement \$ _____ x _____ = \$ _____
Per Paycheck # of Paychecks Plan Year Election

I decline to participate in this option for this year.

I authorize the above elections and adjustments to my annual salary. This agreement is subject to the terms of my Employer's cafeteria plan, as it may be amended from time to time, shall be governed by and construed in accordance with and shall take effect as a sealed instrument under applicable laws, and revokes any prior cafeteria plan election. I have read and agree to the terms of participation set forth on the back of this form.

Employee Signature _____ **Date:** _____

[Reverse Side of Salary Reduction Agreement Form]

I agree that my Compensation will be reduced by the amount of my required Contribution for the Benefit Plans I have elected under the Cafeteria Plan, continuing each pay period until this agreement is amended or terminated. The amount of my required contribution for each Benefit Plan selected is set forth on a schedule that has been provided to me. I understand that:

- I cannot change or revoke any of my elections at any time during the Plan Year unless I have a qualifying Change in Status (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse and such other events as will permit a change or revocation of an election under the Internal Revenue Code, as amended) and the change is caused by and consistent with the Change in Status.
- On separate enrollment form(s) I have enrolled for certain insurance coverage s and understand that an amount equal to the total amount of premiums for coverage(s) elected less any employer contributions allocable thereto will be withheld from my salary. Execution of the Salary Reduction Agreement does not initiate coverage under the component Benefit Plans; coverage will be determined under the separate Benefit Plans.
- Pre-Tax Premiums paid pursuant to this Salary Reduction agreement reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.
- Prior to the Anniversary Date each year I will be offered the opportunity to add or drop coverage for the following Plan Year. If I do not complete and return a new form at that time I will be treated as having elected to continue participation in the Plan on the same basis with the same coverage. Notwithstanding the foregoing, annual elections for participation in the Health Care and Dependent Care Reimbursement Plans must be made by submitting a Salary Reduction Agreement prior to the Anniversary Date of each Plan Year.

See your Summary Plan Description booklet for complete plan details.



**TERMS AND CONDITIONS FOR PARTICIPATING IN
THE DIRECT DEPOSIT PROGRAM FOR
JR3 Education Associates, L.P.
REIMBURSEMENT ACCOUNTS**

You have the option of (1) having your authorized reimbursements for your Reimbursement Account(s) deposited directly into your account at your financial institution or (2) receiving a check for any authorized reimbursements. If you do choose to participate in this Direct Deposit Program (Program), you will need to complete this Authorization Form (Form) and return it to the address below. Please read the following terms and conditions for participation carefully before making your decision.

1. Your financial institution must be a member of an Automated Clearing House before you can participate in any direct deposit program. **Call your bank to make sure they will accept direct deposits.**
2. This Form must be signed and dated and returned to the address below before you can participate in this Program. **If you have a joint account, the form must be signed by both parties.**
3. Once the Form is received by Alt Benefit Consultant, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
4. You will be notified when an electronic transfer is made to your account in a manner set by your employer. The standard turnaround time between the time the funds are transferred and they have been deposited in your bank is two banking days. **Make sure the deposit has been made to your account before you withdraw the funds.**
5. **If an electronic transfer is returned** to Alt Benefit Consultant or cannot be made to your account, Alt Benefit Consultant will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
6. **It is your responsibility to notify Alt Benefit Consultant of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE, and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
7. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be cancelled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
8. This agreement may be cancelled by your financial institution or Alt Benefit Consultant. **Your participation will be cancelled automatically if your employment is terminated or if you terminate participation in the above Account(s).**
9. **You do not have to submit a new Form for a Plan Year if you re-enroll in the above Account(s).** Your participation will continue from Plan Year to Plan Year until you terminate your participation or you do not re-enroll in the Account(s).

Mail Form to: Alt Bentley Yates, Inc. P.O. Box 520, Euless, TX 76040



**JR3 Education Associates, L.P
Section 125 Cafeteria Plan**

Waiver of Participation

Employee Name: _____

Address:

Street Address

City

State

Zip

SS#: _____ DOH: _____ DOB: _____

I elect not to participate in the above referenced Plan and therefore elect to receive my full compensation in cash for the following plan year:

Effective Date: January 1, 2012

I understand that:

- I cannot change or revoke this election to receive full compensation in cash at any time during the plan year, unless I have a qualifying change in status, as stated in my Summary Plan Description booklet.
- Prior to each Anniversary Date I will be offered the opportunity to change my benefit election 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 to continue my election to receive full cash compensation in effect for the new Plan Year.

Employee Signature _____ **Date:** _____