MANN FINANCIAL, INC.
FLEXIBLE BENEFIT PLAN

ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT

Name:	**Social Security Number:**
Street Address:	**BCBSMT Subscriber ID:**
City: State and Zip Code	
E-mail Address:	**Daytime Phone:**
Plan Year : **through**	**Number of Pay Checks in Plan Year:**

In accordance with my rights under the Plan, I elect the following benefits and agree that my compensation will be reduced by the amounts set forth below:

PLAN BENEFIT	**SPENDING ACCOUNT SALARY REDIRECTION FOR PLAN YEAR**	
Medical Reimbursement Expenses	$	
Dependent Care Assistance	$	
Premium Reimbursement	$	
Total		$

FLEXCONNECT CLAIMS ROLLOVER ELECTION – BlueCross BlueShield Group Health Subscribers Only

☐ **I elect to participate in FlexConnect Claims Rollover on my own behalf and as a parent or other personal representative of the following individual(s) who are under the age of 18 years:**

Name	Relationship	Age

By their signatures below, the following individual(s) who are age 18 years or older and are covered under my employer's group health plan elect FlexConnect Claims Rollover as described below.

Note: All covered individuals age 18 years or older must sign this form and must be claimed as a dependent on the participant's tax return. Signing below indicates that the individual has read and understands the FlexConnect Claims Rollover section of this form (page 3).

Printed Name	Signature	Relationship	Age

Employee's Signature _______________ Date _______________

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

By:_______________________________ Date__________________

As an eligible employee in the above Plan, I acknowledge that I have received the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan. If I participate in the Mann Financial, Inc. health plan, my premiums will automatically be withheld on a pre-tax basis through the Health Insurance Premium Account unless during the election period I provide notice, in writing, that I do not wish to participate.

ELECTION FOR INSURED BENEFITS

In lieu of specified dollar amounts, I hereby elect insurance coverage and authorize salary redirections in the amounts of current premiums being charged by the insurance company. I understand that if my required contributions to pay premiums are increased or decreased while this agreement remains in effect, my compensation reduction will automatically be adjusted to reflect that increase or decrease.

ELECTION OF MEDICAL REIMBURSEMENTS

The annual Plan limit which may be allocated to the medical reimbursement account is $3,500. I understand that reimbursements 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, state or local 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. If I cease my employment with the Employer, my participation in the Plan will continue. My salary redirections will continue with after-tax contributions for the remainder of the Plan year. If I incur a change in family status, I may change the amount I have directed towards my Medical Reimbursement Account. 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

The annual Plan limit which may be allocated to the dependent care assistance account is $5,000. I understand that reimbursement will be available only for "qualifying dependent care assistance expenses" as described in the Internal Revenue 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 expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of additional tax owed by me. I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred. I agree to provide the Administrator with the name, address and, if applicable, the taxpayer identification number of the service provider.

This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan year. I will only be reimbursed for amounts up to the balance in my account at the time of my request. I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

PREMIUM REIMBURSEMENT

Employees with outside insurance coverage which qualifies under the Mann Financial, Inc. Flexible Benefit Plan may elect to pay those premiums with pre-tax salary diversions. Eligible insurance may include individual health policies and certain group term life insurance policies.

I understand that I must furnish adequate proof of this coverage and that approval for policy eligibility must be obtained from Employee Benefit Resources, LLP prior to the election form being approved.

If required contributions to pay premiums to a third party insurance company are increased or decreased during the Plan year, I may submit a change in status request and revised election form requesting approval of the increase or decrease to the Outside Insurance Premium spending account election.

OTHER TERMS AND CONDITIONS

I understand that I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the Plan year unless I have a change in status, and my election is consistent with such change. 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 provisions of the Internal Revenue Code.

The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my employer. Any amounts that are not used during a Plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later 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 to continue my insured benefit elections then in effect for the new Plan Year but not my non-insured benefits.

FLEXCONNECT CLAIMS ROLLOVER

As a participant in my employer's Flexible Benefit Plan and my employer's BlueCross BlueShield of Montana group health insurance coverage I understand that I have the opportunity to participate in ***FlexConnect Claims Rollover***. Under ***FlexConnect Claims Rollover***, claims for expenses covered but not reimbursed by the BlueCross BlueShield health plan will be transmitted from BlueCross BlueShield of Montana (BCBSMT) to Employee Benefit Resources, LLP (EBR) and submitted against my medical reimbursement account under my employer's Flexible Benefit Plan – without my having to complete and submit a flex claim form. Once the transmitted claim is received by EBR, it will be applied to my medical reimbursement account within three business days.

However, if I have health coverage through another health plan in addition to my employer's plan, I am not eligible for this feature.

I understand that if I choose to participate in ***FlexConnect Claims Rollover*** that all covered but not reimbursed medical expenses incurred on behalf of my covered family members (or other dependents) and me will be transmitted to EBR from BCBSMT.

By enrolling in ***FlexConnect Claims Rollover*** I acknowledge that:

- All covered family members or other dependents age 18 years or older have signed this election form. ***Note: All my family members age 18 years or older covered by my group health insurance must elect claims rollover or the rollover feature will be available to no one through my health coverage. Only persons claimed as dependents on my tax return may authorize claims rollover.***
- All covered family members or other dependents under the age of 18 years are listed on the completed election form.
- I will complete a new election form upon any change in covered dependents including, but not limited to, birth, adoption, a dependent becoming 18 years of age, or a family member no longer qualifying as a dependent on my tax return. New election forms will be sent to:

  Employee Benefit Resources, LLP
  828 Great Northern Boulevard
  P.O. Box 1193
  Helena, MT 59624-1193

- I understand that I may choose not to participate in the ***FlexConnect Claims Rollover*** feature and that my choice will not affect my ability to obtain treatment, payment, or eligibility for benefits with BCBSMT or my employer's Flexible Benefit Plan.
- I understand this election form is not valid without the required signature(s).
- If I choose to discontinue participation in the FlexConnect Claims Rollover, I understand that I must notify EBR at (406) 449-5500 or (800) 765-9429. Upon receipt of my notice, no future claims either for myself or for family members or dependents enrolled in my group health plan will be automatically submitted to EBR. From that point forward, I agree to submit manual claims on my own behalf.
- I understand that after electing to participate in the ***FlexConect Claims Rollover*** interface, I will have the ability to opt out of the automatic claims submission process and that I may not opt back in to the claims rollover process until the following plan year.