

**McGuire and Hester
Benefit Election Form 1/01/10 thru 12/31/10**

Employee Name	Date of Hire
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ELECTION TO PARTICIPATE

I hereby elect to participate in the McGuire and Hester Benefit Program. The eligible pre-tax benefit I wish to receive through salary reduction is set out below :

PLAN CHOICES	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<input type="checkbox"/> Anthem Blue Cross - Lumenos \$1500 (80/50) <input type="checkbox"/> Anthem BlueCross - Saver \$20 HMO <input type="checkbox"/> Kaiser-High Option <input type="checkbox"/> Kaiser-Low Option	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$	<input type="checkbox"/> \$

<input type="checkbox"/> Dental and Vision	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00
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Health Savings Account	<input type="checkbox"/> Annual HSA Employee Election(in addition to ER cont) \$ _____ H S A can only be elected if Anthem Blue Cross Lumenos \$1500 plan is chosen. McGuire & Hester will deposit \$750 for a single EE/\$1500 for EE w/dependents in a 12 month period. Employee has the option to make an additional annual deposit of up to \$2300 single EE/\$4650 EE w/dependents. If you are 55 or older you may be eligible for the catch up provision and may deposit \$1000 in addition to amounts listed above. Please be sure you understand the eligibility and tax rules of the H.S.A plan prior to enrolling.
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Section 125 Flex Spending	<input type="checkbox"/> Annual FSA Election \$ _____(minimum \$500/maximum \$5000) If you are also electing the H.S.A plan, you must use up the H.S.A funds for medical expenses that are a benefit under your Blue Cross Lumenos \$1500 plan deductible first. Please refer to H.S.A information for more details. <input type="checkbox"/> Annual Dependent Care Election \$ _____(minimum \$500/maximum \$5000)
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McGuire and Hester and I agree that the above-designated amount shall be processed through payroll deductions. By this agreement between McGuire and Hester and myself, I understand the following provisions of the McGuire and Hester Benefit Program:

1. The above election applies to the Plan Year 1/01/10 to 12/31/10 and may not be changed except upon a change in my family status such as: marriage, divorce, death of a spouse or child, birth of a child, or change in spouse's employment such as termination. I have 20 days from the date of the change to submit the appropriate change forms to the McGuire & Hester Human Resources Department.
2. I understand the if I elected the Lumenos \$1500 plan, the H.S.A employer and employee deduction WILL NOT be subject to Federal tax. However, the WILL be subject to state tax. I have read and understand the employer H.S.A contribution schedule.
3. I have been made aware of and understand that all of the appropriate documents relating to the McGuire and Hester Benefit Program including the Summary Plan Description, Rate Sheet, Privacy Notice, Initial COBRA Notice and any other relevant Plan Documents or Notices are available to me and my dependents electronically through McGuire and Hester Intranet or the broker web site at www.filice.com/benefits/mcguirehester I also understand that if I wish to receive a paper copy of any of the above documents, I may do so free of charge by contacting my Human Resource department .

Employee Signature: _____ **Date:** _____

WAIVER OF PARTICIPATION (OPT out option):

I am electing to waive coverage. I understand that my monthly OPT out cash benefit will be paid on a post tax basis.

Monthly OPT out amount \$ _____ (80% of the "lowest" single premium for your age category or \$350, whichever is less) Read OPT out summary to determine your OPT out amount.

If I wish to participate with the McGuire & Hester benefits program at a later date, I must wait until the next Plan Year, unless there is a change in my family status (e.g. marriage, birth of a child, etc.) at which time I can then enroll in the plan.

If I enroll with the McGuire & Hester benefits program during the year due to a change in family status, I understand that my OPT out cash payments will stop.

Employee Signature: _____ **Date:** _____

