Tax Year - 2018

American United Employers, Inc.

Flex Election/Change Form

Medical Expense Reimbursement Plan

1. Name:_____Soc. Sec. _____ - ___ -_____
   (Last) (First) (M.I.)

   Address:_____
   (Street) (City) (State) (Zip Code)

   Marital Status:_____ Sex:_____

2. Action to Be Taken:
   [ ] Enroll in Medical Flex Plan [ ] Discontinue Medical Flex Plan [ ] Change Pre-Tax Amount

3. I select the following coverage option:
   [ ] Employee only [ ] Employee & spouse [ ]Employee & dependents

   [ ] Employee & spouse & dependents [ ] I elect not to participate

4. List eligible family members for Medical Plan coverage:

Relationship	Name	Sex	Date of Birth	Primary Care Provider	SSN
Self	_____	___	_____	_____	_____
Spouse	_____	___	_____	_____	_____
Dependent	_____	___	_____	_____	_____
Dependent	_____	___	_____	_____	_____

I authorize American United Employers, Inc. to deduct the following pre-tax amount from my paycheck each pay period for:

$ _____ x _____ Pay Periods = $ _____ Plan Year Total
(Amount per pay period)

Note: Maximum amount allowed for year 2018 is $2,650.00.

I authorize American United Employers, Inc. to change the amount to be deducted from my paycheck each pay period to the amount indicated below:

$ _____ x _____Remaining Pay Periods = $ _____Plan Year Total
(Amount per pay period)

5. The Medical Plan is included in our Cafeteria Plan and is, therefore, covered by Section 125 of the Internal Revenue Code. Once an election for coverage is made, the IRS regulations will not permit a change in this coverage until the next annual enrollment date, unless the change is due to a change in status as listed below and the change in my status and need for election change are consistent, as required under the family status rules:
   - marriage; divorce; death of a spouse or dependent; birth of a dependent; birth or adoption of a child; change in number of dependents;
   - termination of employment or commencement of employment; a strike or lockout; commencement or return from an unpaid leave of absence; a change in worksite; or any change in employment status that affects eligibility;
   - a change in residence for you, your spouse or children;
   - or your dependents either satisfies or ceases to satisfy requirements for coverage due to change in age, student status, or any similar circumstances;
   - or a change in my or my spouse's employment status.

6. Authorization and Agreement:

   I have read the information describing the Medical Plan and agree to abide by the terms of the Plan Document. I recognize I must submit signed documents and a Reimbursement Request Form to the Plan's Administrator for the reimbursement of qualified expenses, as determined by the Internal Revenue Code. I further recognize that any unused amounts remaining in my Account after the close of a Plan Year will be forfeited. I understand that I will have a specified time period (determined by the Company) in which to submit qualified expenses following the close of a Plan Year or upon termination of participation. This time period will be communicated to me by the Company.

I understand that this application is only valid for the plan year listed at the top of the application and it does not automatically renew, I must complete a new application for each plan year.

Employee's Signature _____ Date: _____

Received by: _____ Date: _____

Effective Date: _____Date Sent to Payroll: _____

American United Employers, Inc.
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