Tax Year - 2020

American United Employers, Inc.

Flex Election/Change Form

Dependent Care 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 Dependent Care FSA [ ] Discontinue Dependent Care FSA [ ] Change Pre-Tax Amount

Note: This authorization is for the Plan Year ending December 31 in the year ***2020***. Accounts may be set up prior to the Plan Year in which they are to take effect and CANNOT be changed during that Plan Year EXCEPT for changes in status outlined in the SPD.

3. Dependent Care FSA Enrollment:

I authorize American United Employers, Inc. to contribute the following pre-tax amount from my paycheck each pay period to my Dependent Care Reimbursement Account:

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

Note: Maximum annual Dependent Care Expenses allowed is $5,000.00

4. Dependent Care FSA Change:

I authorize American United Employers, Inc. to change its contribution to the Dependent Care Reimbursement Account on my behalf as follows:

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

5. Authorization and Agreement

I have read the information describing the Dependent Care Reimbursement 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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