

The Institute for Behavior Change, Inc.

Steven A. Kossor, Executive Director

Federal EIN: 23-2935316

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phone or fax
(610) 524-8701

There are no obstacles, only hurdles of varying heights. None is so great that it cannot be overcome, gotten around or gone under. Even mountains disintegrate with time.

Payroll Redirection Agreement

Employee Name: _____ Employee Social Security Number: _____

Employee's Full Address: _____

Employee Birth Date: _____ Employee Hire Date: _____ Employee Effective Date: _____
(1st of the Month following 90 Days)

The Institute for Behavior Change, Inc., and I hereby agree that my cash compensation will be reduced by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement). I understand that if I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all of the programs under my employer's Flexible Benefits Plan. I understand that The Institute for Behavior Change, Inc., reserves the right to amend or discontinue the plan or any provision without prior notice to, or consultation with, any plan participant.

Employee's Flexible Benefits Deduction/Allocation Per Pay

Payroll deduction for 26 Pays/Year (subject to changes in the Benefit Agreement) **Employee Contribution Rates***

Health Insurance		Partial Plan 1 Description		Partial Plan 2 Description	
Employee	99.98	Plan DPOS-5	129.42	Plan DPOS-3	
Parent/Child(ren)	203.16	OV Co-pay \$30 reg / \$50 Specialist	255.48	OV Co-pay \$20 reg / \$40 Specialist	
Employee/Partner	271.49	ER Co-pay \$100 Gen: \$7 Brand: 50%	339.23	ER Co-pay \$100 Gen: \$10 Brand: 20%	
Dental Insurance			Partial Plan Description		
		Employee	12.76	Plan ACCESS PPO 6600	
		Parent/Child(ren) or Employee/Child	25.20	Individual Annual Deductible \$50	
		Family	39.48	Annual benefit maximum \$1,000	

***Rates are subject to adjustment based on final rates from Keystone Health Plan East (Health) or Dominion Dental (Dental). Full plan details are available in Plan documents delivered to eligible employees by the Plan Administrator.**

Please check here if you wish to waive enrollment in the health insurance plan: _____ for yourself.

I wish to waive enrollment for my dependents in the health care plan _____.

I wish to waive enrollment in the health care plan for myself and for dependents. _____.

Please indicate other insurance plan under which you or your dependents have coverage (Employer Name _____; Insurance Company _____)

I understand that there are laws governing my rights to change this election to waive coverage, and that I may make a change in my election under the Plan in accordance with these laws.

I understand that:

1. If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirected will automatically be adjusted to reflect that increase or decrease.
2. Prior to the first day of each plan year, 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 pre-tax benefit coverage then in effect for the new plan year. In addition, this compensation redirection agreement will continue by its terms in the amount of the required contribution for the benefit option.
3. I cannot revoke or change this taxable compensation redirection agreement at any time during the plan year unless I have a change in family status (including marital status, employment status, residence, number of dependents or change in dependent's eligibility), or such other events as the Plan Administrator determines will permit a change or revocation of an election. Such changes must be consistent with the change in family or employment status, and in accordance with current Treasury Regulations in effect. I agree to notify my employer if I have a change in Family Status.
4. I understand that certain benefits require insurance applications, and if I do not complete the required forms, I will not be covered for those benefits.
5. The Plan Administrator may reduce or cancel my taxable compensation redirection or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
6. This agreement is subject to the terms of The Institute for Behavior Change's Flexible Benefits Plan, as amended from time to time, and shall be governed by applicable laws. This agreement revokes any prior election and Taxable Compensation Redirection Agreement relating to such plan.

Employee Signature _____ Date _____