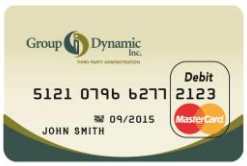
FLEXIBLE BENEFIT ELECTION FORM
Iwaki America, Inc.



October 1, 2019 through September 30, 2020

Keep your card from year to year!

The Flexible Benefit Plan allows you to make your contribution toward your benefits with pre-tax dollars. These dollars are not subject to FICA, federal or state income taxes. The plans covered by this agreement are listed in the **Summary Plan Description** and include the Flexible Spending Accounts listed below.

		Annual	**Per Pay**
Medical Care Flexible Spending Account For reimbursement of eligible medical care expenses for you, your IRS-defined spouse & qualified dependents **who do not contribute to a Health Savings Account (HSA)**			
Minimum: Maximum:	$ 0 per plan year $ 2700 per plan year	$	$
Limited Purpose Medical Care Flexible Spending Account For reimbursement of eligible medical care expenses for you, your IRS-defined spouse & qualified dependents **who contribute to a Health Savings Account (HSA)***			
Minimum: Maximum:	$ 0 per plan year $ 2700 per plan year	$	$
Dependent Care Flexible Spending Account For reimbursement of eligible work-related child care or elder care expenses			
Maximum:	$ 5000 per year *Single/Married, filing jointly* $ 2500 per year *Married, filing separately*	$	$
Debit Card Choices *Medical or Limited Purpose FSA only*	☐ **Please load my existing card with my election for the new plan year.** ☐ **I do not have a GDI Debit Card and would like to order one.** ☐ **No, I do not want a GDI Debit Card. I prefer to submit reimbursement requests on-line or use a Reimbursement Request form.**		

* **My signature below indicates my understanding that if I or my spouse are enrolled in a High Deductible Health Plan and contribute to a Health Savings Account (HSA), my pre-tax Medical Flexible Spending Account dollars are limited to vision, dental or preventive care expenses until I have met the federally mandated amount of deductible expenses.**

I agree to have my compensation reduced each payroll period during the plan year to cover my contribution toward the benefits selected above. I understand this agreement will remain in effect until the end of the plan year unless one of the following events occurs: A change in legal marital status due to marriage, divorce, legal separation, annulment, or my IRS-defined spouse's death; a change in the number of my qualified dependents due to birth, adoption, placement for adoption, or death; a change in employment status for me, my spouse or qualified dependent that affects benefits eligibility, such as termination or commencement of employment, a reduction or increase in hours worked, a strike or lockout, commencement of, or return from an unpaid leave of absence, or a change in worksite; an event that causes my qualified dependent to satisfy or cease to satisfy status as a qualified dependent; a change in my, my spouse's or my dependent's residence; special enrollment rights; certain judgments, decrees and orders; entitlement to Medicare or Medicaid; certain changes in cost; and certain changes in coverage. Each of these events is defined in the **Summary Plan Description** and any request for change will be governed by the terms outlined in the Summary Plan Description and the underlying group health plans (when applicable). I further understand that in the event the cost of a non-Flexible Spending Account benefit I have selected changes during the year, the Plan Administrator may make a corresponding adjustment to automatically increase or decrease the amount by which my compensation is reduced to provide such benefit.

I certify that my GDI Debit Card will be used only for payment of qualifying medical expenses that have been incurred by me or my qualified dependents. I acknowledge that I have received information on qualifying medical expenses. Further, I agree to save all invoices and receipts for any expense I pay with the Card and, upon request, to submit these documents for review by the Plan.

Employee Name (please print) _____ Social Security Number _____

Employee Date of Hire _____ Employee Date of Birth _____ Email address _____

Address _____ City _____ State _____ Zip _____

Employee Signature _____ Date _____

Human Resources/Payroll please complete: Effective Date: _____ First P/R Date: _____ Payroll Cycle: W B S M

IRS regulations prohibit sole proprietors, LLC members and greater than 2% subchapter S Corp. owners from participating in a flexible benefit plan.