I. ELECTION AND SALARY REDUCTION AGREEMENT FOR INSURANCE PREMIUMS

On the appropriate benefit enrollment form(s), I have enrolled for health and/or dental insurance coverage at St. Lawrence University. I agree to have St. Lawrence University reduce my salary by the extent necessary to pay my portion of the premiums for the following benefits:

- Health insurance (pre-tax premiums and applies only if coverage is contributory)
- Dental Insurance (pre-tax premiums and applies only if coverage is contributory)

In addition to the Other Terms and Conditions set forth on the back of this election form, I understand that:

- If my required contributions for health or dental insurance coverage are increased or decreased while this agreement remains in effect, my salary reduction will automatically be adjusted to reflect that increase or decrease.
- Prior to the first day of each plan year I will be offered the opportunity to change my 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 the pre-tax premium election into the new plan year. (Note: this automatic continuation applies only to premiums, not to Medical/Dependent Care Reimbursement Accounts).

II. ELECTION AND SALARY REDUCTION AGREEMENT FOR FLEXIBLE SPENDING ACCOUNTS (FSA)

General instructions for Reimbursement Accounts:

- You may enroll in either one or both of the reimbursement accounts.
- The minimum contribution to either account is $120.00 per year.
- The maximum contribution to a Medical Care Reimbursement Account is $2,500 per year.
- The maximum contribution to a Dependent Care Reimbursement Account is $5,000 per year (or $2,500 if you are married and file a separate tax return).

I elect to participate in the following reimbursement account(s), and I agree to have St. Lawrence University reduce my salary by the amount(s) indicated below:

<table>
<thead>
<tr>
<th>Account Type</th>
<th>Annual Contribution</th>
<th>Number of payrolls (see below)</th>
<th>Contribution per pay period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care Reimbursement Account</td>
<td>(max $2,500)</td>
<td>+</td>
<td>=</td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account</td>
<td>(max $5,000)</td>
<td>+</td>
<td>=</td>
</tr>
</tbody>
</table>

*Hourly employees: use 26 pay periods  *Seasonal employees: use 18 pay periods

Please be sure to read all terms and conditions on the back of this form before you sign!
Other Terms and Conditions

As a participant, I understand that:

- Reimbursements will be available only for “qualifying medical expenses” or “qualifying dependent care expenses,” as appropriate, for each separate reimbursement account. I agree to notify the University if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the University on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a nonqualifying expense, up to the amount of the additional tax actually owed by me.

- Any amounts that are not used during a plan year to provide benefits will be forfeited and will not be paid to me in cash nor used to provide benefits specifically for me in a later plan year.

- I cannot change or revoke any of my elections or this salary reduction agreement at any time during the plan year unless I have a qualifying “change in status.” Changes in status include marriage, divorce, legal separation or annulment; death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse; participant’s or spouse’s employment status changes from full-time to part-time or vice versa; participant or spouse takes an unpaid leave of absence.

NOTE: You are permitted to change elections if you have a change in status which results in you, your spouse or dependent gaining or losing eligibility for coverage under your employer’s health plan or your spouse’s or dependent’s health plan. The change you make must be consistent with that gain or loss of coverage. These situations include: a reduction or increase in hours of employment by the employee, spouse, or dependent including a switch between part-time and full-time, a strike or lock-out, or commencement or return from an unpaid leave of absence; an event that causes an employee’s dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, a change in the place of residence or worksite of the employee, spouse or dependent, and any other events permitted by Treasury Regulations.

Any change in benefit elections resulting from a change in status must be consistent with, and on account of, the event. If you experience a change in status and wish to change your benefit elections, it is your responsibility to notify the Benefits Administrator within 30 days of the event.

- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.

- My Social Security benefits may be reduced as a result of my election.

- Both my premium and reimbursement elections will terminate at the time I terminate employment unless I elect to continue making contributions on an after-tax basis, subject to the provisions of the Plan Document.

This salary reduction is not effective for any period that begins before you have signed this form and returned it to the Plan Administrator.

Employee’s Signature: __________________________ Date: __/__/