Please complete all fields

Participation Agreement for the Flexible Benefits Plan

Plan Year Effective: January 1, 2015 through: December 31, 2015 *First Payroll Effective Date: 01/01/2015*

Employer Name: Cajun Industries, LLC *Paycheck Frequency: Weekly*

Name: ____________________ *Date of Birth: ____________________*

Address: ____________________ *City, State Zip: ____________________*

Social Security Number: ____________________ *Date of Hire: ____________________*

Email Address: ____________________ *Work Phone (_______) ____________________*

Spouse's or Dependent's full name for 2nd Take Care debit card: ____________________

Check (✓) Each Option

OPTION I: Cafeteria / Healthcare Flexible Spending Account (FSA) Agreement

_______: I elect to contribute $_________ (before taxes) per pay period, which is $ ___________ per plan year, to fund my account for reimbursement of qualified healthcare expenses not covered under my health and other insurance plans, up to an annual limit specified by my Plan.

_______: I decline to participate in this option for this plan year.

OPTION II: Dependent Daycare Reimbursement Account Agreement

_______: I elect to contribute $_________ (before taxes) per pay period, which is $____________ per plan year, for funding of qualified dependent daycare expenses. (Maximum amount per calendar year is the lesser of; (1) $5,000 for married filing joint, or $2,500 for married filing separate; (2) your spouse's total annual compensation; or (3) 1/2 of your total annual compensation. If you are single, the maximum amount is $5,000.)

_______: I decline to participate in this option for this plan year.

OPTION III: Health Savings Account (HSA) Contributions & Limited Health Flexible Spending Account

☐ YES I elect to contribute $ ________(before taxes) per pay period, to fund my Health Savings Account (HSA).
I elect to contribute $_________ (before taxes) for the PLAN YEAR, which is $ ___________ per pay period, to fund my Limited Health FSA for qualified expenses. I understand that my Health Flexible Spending Account will be a "***limited health flexible spending account***" for reimbursement of ***dental, vision and preventative care*** only up to the maximum of my employer plan.

☐ NO I decline to participate in this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

Saving Taxes on Insurance Premiums

If I have enrolled in certain employer-sponsored insurance benefits, I understand that my share of the premium for these insurance benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my taxable income will automatically be adjusted to reflect that increase or decrease. If I wish to decline saving taxes on insurance premiums, I must affirm this with my employer in writing before the start of each plan year.

PLEASE READ CAREFULLY

HEALTH CARE FLEXIBLE SPENDING DEBIT CARD AGREEMENT: By signing and using the *TakeCare Benefits* card I agree to the terms of the Funds Transfer Disclosure Statement ("Agreement") received with the card. Use of the card is authorized for qualified healthcare expenses only as outlined in my Plan Documents. I certify that expenses will not be reimbursed under any other health plan coverage. Upon request, I will immediately submit any other documentation requested by the OMNI Group, the Plan Administrator. Failure to submit such documentation may result in: (1) my obligation to repay the amount to my employer; (2) immediate suspension or revocation of the Card, and/or (3) taxable, payroll deductions by my employer of the ineligible expenses.

PARTICIPATION / WAIVER: My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may not change my annual election except in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge that I have received, read and understand the Summary Plan Description. If I voluntarily waive coverage under Option IV, I understand the benefits of participating in the plan and that if I should later desire to participate I will have to wait until the next Plan Year unless I experience an official change in family status.

SIGNATURE: ____________________ DATE: ____________________