NOTICE OF CONTINUATION OF BENEFITS OPTION FOR MEDICAL EXPENSE REIMBURSEMENT ACCOUNT PARTICIPANTS

This is to inform you that even though you will no longer be eligible to participate as an employee in the Section 125 Flexible Benefits Plan as of _____, 20_____, you and your dependents may continue your benefits under the Medical Expense Reimbursement Plan beyond this date. If you chose to continue under the Plan, your claims will be processed until the first of these conditions is met:

a) You have received the full amount of your original annual election under the Medical Expense Reimbursement Plan as payment for expenses incurred;
b) The Plan Year ends (there is a ninety (90) day grace period after the Plan Year ends during which you may submit all eligible expenses incurred during the Plan Year); or
c) The Medical Expense Reimbursement Plan is no longer in force.

During the current Plan Year enrollment period, you elected an Annual Medical Expense Reimbursement of $ _____, for which you have been contributing $_____ per pay period. You have the right to continue to use the full amount of your original Annual Election by having your ANNUAL BALANCE DUE deducted pre-tax from your remaining or final paycheck(s), or by continuing to make monthly after-tax contributions at the rate of 102% of the ANNUAL BALANCE DUE divided by the number of months remaining in the Plan Year.

CALCULATION OF ANNUAL BALANCE DUE

ORIGINAL ANNUAL MEDICAL EXPENSE BENEFIT ELECTION:			$_____ (A)
TO-DATE CONTRIBUTIONS:	**Number of Contributions**		
Per Payroll Contribution: $_____	x	**Made to Date:** _____	$_____ (B)
ANNUAL BALANCE DUE TO CONTINUE RECEIVING BENEFITS:		(A) - (B)=	$_____ (C)

If you do not authorize payment of the full amount required, you waive your option to continue coverage and any medical expenses incurred after your date of termination will not be eligible for reimbursement, although you may continue to submit claims for expenses incurred prior to your termination date.

I HAVE READ THE ABOVE AND UNDERSTAND MY OPTIONS CONCERNING CONTINUATION IN THE MEDICAL EXPENSE REIMBURSEMENT PLAN. I HEREBY CHOOSE THE FOLLOWING OPTION: **(select one)**

_____ YES -- I wish to continue my benefits under the Plan. I hereby authorize Payroll to withhold the ANNUAL BALANCE DUE in its entirety of my original annual election, shown as Figure (C), pre-tax from my pay to continue my participation in the Medical Reimbursement Plan.

_____ YES -- I wish to continue my benefits under the Plan. I agree to make monthly payments at the rate of 102% of the ANNUAL BALANCE DUE divided by the number of months remaining in the Plan Year.

_____ NO -- I DO NOT wish to continue my employee benefits under the Plan. I realize that by not continuing coverage under the Plan, any medical expenses incurred after I make my final payroll contribution will not be eligible for reimbursement, even if I have already made contributions beyond the amount I have been reimbursed for.

_____ _____ _____
Signature of Employee Social Security Number Date

_____ _____
Authorized Company Representative Date