Participation and Salary Reduction Agreement
Fisheye Software
Fisheye Software Cafeteria Plan
Plan year: January 1, 2014 through December 31, 2014

I. Participant Identification (please print or type)

Participant Name: _____ **Social Security Number:**

Address_____ **City, State, Zip**_____

II. Agreement to Participate

Please check one box below. If you decline participation in the Plan, do not complete section III. Sign and date the form in this section II and return to the Benefits Coordinator.

☐ I elect to participate in the Cafeteria Plan. (Please complete section III.)

☐ I decline participation in the Cafeteria Plan. I understand that I may not enroll for the remainder of this Plan Year, unless I have a Change in Status, as defined under the Plan.

_____ _____
Employee's Signature Date

III. Salary Reduction Agreement

Check the boxes for the benefits you are selecting and indicate the amount of salary reduction for biweekly pay period for the Medical Flexible Spending Account and Dependent Care Flexible Spending Account. The amount of salary reduction needed to pay premiums under the Plan will be determined by the insurance company. This amount will be changed as necessary, if the premium charged by the insurance company changes.

I hereby authorize my employer to reduce my cash compensation as indicated below for each pay period during the Plan Year following the date of this agreement.

Premium-type Benefits (Salary reduction determined by premium rate)

**** HMO / PPO Option ****	**** Dental ****
☐ Employee Only	☐ Employee Only
☐ Employee plus Dependents	☐ Employee plus Dependents

Flexible Spending Arrangements **Salary Reduction**

☐ Dependent Care FSA (not to exceed $5000 annually)

☐ Medical Expense FSA (not to exceed $2500 annually)

I understand that this election form cannot be revoked or changed during the plan year, unless there is a change in my status (e.g. marriage, divorce, death of spouse or child, birth or adoption of child, and termination of employment of spouse) which justifies the revocation or change.

I understand that salary reductions must be reimbursed for qualified expenses incurred during the plan year and may not be carried over into future plan years. If at the end of the plan year, the total reduction in compensation exceeds the substantiated expenses, the difference in amounts will be the property of the employer.

I have examined this agreement and to the best of my knowledge, it is true, correct and complete.

_____
Participant's Signature Date

_____
Agreed and accepted by Date
the Employer's Representative