

PREMIUM CONVERSION ACCOUNT (PCA) ELECTION FORM

Instructions: Employees enrolling complete Sections I, II, and IV. Employees changing their current election complete Sections I, III, and IV.

I. IDENTIFYING INFORMATION

Last Name, First Name, Middle Initial

Social Security Number

Mail Stop: Extension:

II. ENROLLMENT

My enrollment is based on: First eligible Qualifying status change Open Season

I understand my PCA election is irrevocable for the rest of the plan year. I elect to participate in the Board's PCA and reduce my taxable compensation in the amount of my annual INSURANCE premiums for:

Health Dental Vision

III. CANCELLATION (check appropriate line)

I elect to cancel participation in the Board's PCA for my share of Health Dental Vision All

Event which permits change Date of event

Attach a copy of the corresponding health, dental and/or vision election form, if applicable. Use Remarks section below to provide any additional explanation.

IV. SIGNATURE

My signature here certifies I have read the above notice regarding this program and I understand: 1) the tax implications of participation (or non-participation) in the PCA; and 2) that I cannot change or cancel this election prior to the next Plan Year (starting in January) unless I experience a qualifying status change and make a corresponding change in my health, dental and /or vision coverage.

Employee Signature Date

V. ADMINISTRATOR'S CERTIFICATION AND ACCEPTANCE OF ELECTION

I certify that the above-named employee is eligible to make the election indicated above and that the election is in accordance with the Plan.

Authorized Signature Date

Effective Date of Election

Pay Period Effective Date

Remarks

Privacy Act Statement: The information you provide on this form is needed to document, in your personnel, payroll, and retirement records file, your election to participate or waive participation in the PCA. This information will be shared with any individual or entity used by the Administrator to assist in the administration of the PCA and it will be used to identify you. This information may also be disclosed to other Federal agencies and Congressional offices that have a need for the information in connection with your application for a job, license, grant, or other benefit. It may also be shared with national, state, local, and other charitable or social security administrative agencies for those agencies to determine and issue benefits under their programs. To the extent this information indicated a possible

violation of civil or criminal law, it may be shared with the appropriate federal, state, or local law enforcement agencies. The information may be disclosed in legal proceedings in connection with your employment at the Board. Executive Order 9397, November 22, 1943, authorizes the use of your Social Security Number to distinguish you from people with similar names. Maintenance of this information is authorized by Section 10 of the Federal Reserve Act (12 USC 244). Furnishing your Social Security Number and other information is voluntary, but your failure to do so may result in a delay in the receipt of benefits, and may result in the reclassification of any benefits you receive.

I have read the PCA Summary Booklet and I understand the following:

The Premium Conversion Account (PCA) is a means for eligible employees to pay their required share of health, dental and/or vision premiums on a pre-tax basis through salary reduction.

I cannot change or cancel this agreement during a Plan Year, unless the change is consistent with a status change that permits a change in my health, dental and/or vision insurance enrollment (i.e., marriage, divorce, death of a dependent, birth or adoption of a dependent, change in work hours, termination of a spouse's employment, or such other event permitting a change or revocation of an election).

I will have the opportunity to change or cancel this agreement for the following plan year as provided by the Plan. If I do not complete and return a new PCA election form during the period specified by the Plan Administrator, I will have automatically elected to continue my current PCA election for the following year with a reduction in compensation determined in accordance with the Plan. I understand that the reduction in compensation may be larger or smaller for the following year than it is for the current year.

If health, dental and/or vision plan premiums change due to an

insurance company change while this agreement remains in effect, my taxable compensation will be automatically adjusted to reflect that change, in accordance with the Plan.

The PCA Administrator may reduce or cancel the amount of my PCA salary reduction, or otherwise modify this agreement, if necessary to satisfy certain provisions of the Internal Revenue Code, including but not limited to Section 125. I will be notified of any such actions.

The salary reduction I have elected under this agreement will be in addition to any reductions under other agreements or benefit plans, (such as Thrift Plan Deferred Compensation).

While the Board expects to continue this PCA indefinitely, it reserves the right to change, suspend, or terminate the Plan at any time.

The information provided by the Administrator, including any information provided in this form, is intended to help me understand the Plan. However, the Plan Document sets forth the terms of this Plan and shall be controlling over this or any other information provided by the Administrator.

PCA Election Form

Follows This Notice