SURA/Jefferson Lab
2006 PRE-TAX ELECTION FORM

12000 Jefferson Ave. Newport News, Virginia 23606
Telephone (757) 269-7576 FAX (757) 269-7559

Employee's Name	Social Security Number	Birth Date
Home Address	City, State	Zip Code
Employer's Name **Jefferson Science Associates, LLC**	Business Telephone	Home Telephone
Date of Hire	Eligibility Date	Email Address

I elect the following tax-free benefits and hereby agree for my cash compensation to be reduced by the amounts set forth below for each pay period during the plan year **April 1, 2006 - March 31, 2007** (or during such portion of the year as remains after the date of this agreement).

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

[ ] I elect to have $ _____ per pay period placed in a Healthcare Spending Account.

[ ] I do not elect to participate

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

[ ] I elect to have $ _____ per pay period placed in a Dependent Care Account.

[ ] I do not elect to participate

WAIVER OF PARTICIPATION

I acknowledge that I have been given the opportunity to become an enrollee in my employer's flexible benefit plan. However, I have chosen not to participate at this time. By waiving participation, I realize that I will not again become eligible to participate until the next plan anniversary date, or if earlier, occurrence of a life event.

I elect to receive reimbursements from my spending account(s) for the plan year by:

_____ Direct Deposit Into My Checking _____ Savings (Please Attach A Voided Check) **OR**
_____ Check Mailed To My Home _____ Use information already on file

This agreement will continue until (1) I cease to be eligible to participate in the Plan; or (2) I terminate or amend this agreement during an annual enrollment period; or (3) My employer terminates, suspends, or modifies the Plan; or (4) An eligible event occurs that makes it necessary for me to modify this agreement.

I have made the above election regarding the benefits made available to me. I understand that: (1) I cannot change this election during the plan year unless I have a "Life Event" (Internal Revenue Code Restrictions Apply), such as termination of employment or change to part-time status by either myself or my spouse; marriage; divorce; death of an immediate family member; birth or adoption of a child; or significant change in premiums or benefits of the health coverage maintained either by me or my employer; (2) Any amounts remaining in my personal reimbursement account(s) at the end of the plan year will be forfeited; (3) This election replaces any previous election; (4) My social security benefits may be slightly reduced as a result of my election.

Signed _____ Date _____

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EMPLOYEE BENEFITS MANAGEMENT, LLC

Jefferson Science Associates,LLC

Authorization for Use of Disclosure of Protected information to spouse and/or dependents.

I,_____, hereby authorize *Employee Benefits Management, LLC* to release protected health information and/or account information to:

Name	**Relationship**	**SSN or Password**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Employee Benefits Management, LLC may release health and/or account information to the above, involving **(circle those that apply) healthcare spending account and dependent care spending account**; including, but not limited to, date of service, type of service provided, account balances, confirmation of receipt, and/or issue date and amount of check.

This authorization is valid **until revoked in writing**.

Signature_____ Date_____