PREMIUM DEDUCTION AUTHORIZATION

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution election amounts will be deducted from my paycheck by my employer. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage election amount as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. Pre-tax contributions reduce my compensation for Social Security tax purposes therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible benefits plan as elected in the pre-tax column. My employer's deduction of any premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

November 1 st , 2015 begins these coverages.	Pre-Tax Bi-Weekly	Post Tax Bi-Weekly	Waive
Payroll Deductions begin on 11/13/2015			* * * * * * * * * * * * * * * * * * *
Short Term Disability	in the second	ALI	
Illinois Mutual		(8)	Truck of
Accident	- to a	A	
Illinois Mutual	5.84	18.88	erala e
Critical Care Protector Plus	6728 6 P. W		2/
Combined Insurance	F . 100 ()	i des _i a a l	X
Hospital Medical Bridge			X
Colonial Life	rifaan soo a si		
Dental			1 /
Delta Dental	W to see the	i whi	1 may 2 m
	d te d the common	grafi er de effere søg e	
Term Life Insurance	antana na principale p	with the state	
Illinois Mutual		and the second of the	. *************************************
Total:	assistant of the special		
Market and an arrange of the second of the s	j		1

Illinois Mutual	is spacetime to		1000
Accident Illinois Mutual		18.88	11 12 14 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Critical Care Protector Plus Combined Insurance	SAME DESCRIPTION	a 18 - 1975 a ja Majara 19	X
Hospital Medical Bridge Colonial Life	r fash in a si		X
Delta Dental			X
Term Life Insurance Illinois Mutual	Medalo William (r we do live in the live Live of 198	
Total:		e estado e e estado e e e e e e e e e e e e e e e e e e e	a, k
EMPLOYEE FIRST AND LAST NAME REN	sta An	derson	- 1-5 - 2-3
REQUIRED ACKNOWLEDGMENT TO PARTICIPAT I certify that the features and benefits under the acknowledge that I understand the Important In the back of this form and agree to be bound by the Benefits Plan. EMPLOYEE'S SIGNATURE	e Flexible Benefits Plan ha Iformation Regarding Part	ve been explained to me ticipation in the Flexible	Benefits Plan on
GENERAL WAIVER OF PARTICIPATION I certify that the features and benefits of the pla understand that these policies are offered throu participation in Liberty Classical Academy's benefit	igh my employer by payro		

EMPLOYEE'S SIGNATURE	DATE
EIVIPLUTEE S SIGNATURE	DATE

- Restrictions on Election Changes: On or after the first day of the plan year, I cannot change or
 revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next
 anniversary date of the plan unless a change in status occurs (as defined under the plan and the
 Internal Revenue Code), and the change is caused by and consistent with the change in status.
- Commencement of Coverage and Status of Prior Elections: Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or insurance policies. The terms and conditions and actual coverage effective date of the Underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop, or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue.
- <u>Use of Personal Information:</u> In addition to and without limiting in any way the rights my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status, and health and dependent child care information) as is reasonably required to administer the plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure, or release of such information so long as there is information is used in furtherance of plan administration, or to detect or prevent fraud or misrepresentation.
- Effect of Pre-Tax Contributions on Benefits Payments: Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverages may be funded on an after-tax basis to preserve the excludability of policy benefits.
- PLAN DOCUMENT CONTROLS: I verify that I have received a summary of the tax rules, operational guidelines, and procedures for use with the Cafeteria Plan. I understand that the plan document will control notwithstanding any contrary oral representation by any person.

PREMIUM DEDUCTION AUTHORIZATION

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November 1 st , 2015 begins these coverages. Payroll Deductions begin on 11/13/2015	Pre-Tax Bi-Weekly	Post Tax Bi-Weekly	Waive
Short Term Disability Illinois Mutual	ty in mother y	12,24	True
Accident Illinois Mutual			DY
Critical Care Protector Plus Combined Insurance	The second of the second		DZ
Hospital Medical Bridge Colonial Life			DY
Dental Delta Dental	101 % A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		22
Term Life Insurance Illinois Mutual	wholes a distri-	e german ing geri	DY
Total:		12.24	

HOSPITAL MEDICAL Dridge			1 / IAA			
Colonial Life		(a. 17) (a. 17) (a. 17)	MY			
Delta Dental			DY			
Term Life Insurance Illinois Mutual	Mark Barry Romann John Rom	von Le ned	DY			
Total:	arasia i e vez, barga t	12,24				
REQUIRED ACKNOWLEDGMENT TO PARTICIPA' I certify that the features and benefits under the acknowledge that I understand the Important In the back of this form and agree to be bound by Benefits Plan. EMPLOYEE'S SIGNATURE GENERAL WAIVER OF PARTICIPATION I certify that the features and benefits of the plan	EMPLOYEE'S SIGNATURE DATE 10-21-15 GENERAL WAIVER OF PARTICIPATION certify that the features and benefits of the plans listed above have been explained to me completely. I understand that these policies are offered through my employer by payroll deduction. I have decided to waive my					
EMPLOYEE'S SIGNATURE	***************************************	DATE				

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 revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next
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- Use of Personal Information: In addition to and without limiting in any way the rights my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status, and health and dependent child care information) as is reasonably required to administer the plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure, or release of such information so long as there is information is used in furtherance of plan administration, or to detect or prevent fraud or misrepresentation.
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Short Term Disability Illinois Mutual	,		SH
Accident Illinois Mutual	11.12		
Critical Care Protector Plus Combined Insurance	9.84		
Hospital Medical Bridge Colonial Life	V V	×	SA
<u>Dental</u> Delta Dental			SA
Term Life Insurance Illinois Mutual			SH
Total:	2096		*

Delta Dental		30 °	SA
Term Life Insurance Illinois Mutual			SA
Total:	2096		
EMPLOYEE FIRST AND LAST NAME	Susanne,	tbrn	
REQUIRED ACKNOWLEDGMENT TO PARTICIPAL I certify that the features and benefits under the acknowledge that I understand the Important In the back of this form and agree to be bound by Benefits Plan. EMPLOYEE'S SIGNATURE	e Flexible Benefits Plan ha nformation Regarding Part	ve been explained to me ticipation in the Flexible	Benefits Plan on
GENERAL WAIVER OF PARTICIPATION I certify that the features and benefits of the pla understand that these policies are offered throu participation in Liberty Classical Academy's benefits	igh my employer by payro		
EMPLOYEE'S SIGNATURE		DATE_	

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- <u>Use of Personal Information:</u> In addition to and without limiting in any way the rights my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status, and health and dependent child care information) as is reasonably required to administer the plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure, or release of such information so long as there is information is used in furtherance of plan administration, or to detect or prevent fraud or misrepresentation.
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Payroll Deductions begin on 11/13/2015			
Short Term Disability			2 1
Illinois Mutual			RR
Accident	0.00		
Illinois Mutual	18.75		e a
Critical Care Protector Plus			
Combined Insurance	,		RN
Hospital Medical Bridge			00
Colonial Life			RIC
Dental			
Delta Dental			RR
Term Life Insurance			
Illinois Mutual			RR
Total:	18.75		

Illinois Mutual	18, 13		d
Critical Care Protector Plus Combined Insurance			RN
Hospital Medical Bridge Colonial Life			RR
Delta Dental			RR
Term Life Insurance Illinois Mutual			RR
Total:	18.75		
REQUIRED ACKNOWLEDGMENT TO PARTICIPA I certify that the features and benefits under th acknowledge that I understand the Important II the back of this form and agree to be bound by Benefits Plan.	e Flexible Benefits Plan ha nformation Regarding Par	PLANS: ave been explained to me ticipation in the Flexible	Benefits Plan on
EMPLOYEE'S SIGNATURE_Rebecce	a Renst	ON DATE_	10/20/19
GENERAL WAIVER OF PARTICIPATION I certify that the features and benefits of the planderstand that these policies are offered throuparticipation in Liberty Classical Academy's ben	ugh my employer by payro		
EMPLOYEE'S SIGNATURE		DATE	

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At a st a set 5			
November 1 st , 2015 begins these coverages.	Pre-Tax Bi-Weekly	Post Tax Bi-Weekly	Waive
Payroll Deductions begin on 11/13/2015			1
C1			
Short Term Disability	}		1
Illinois Mutual			0-/
			100
Accident			
Illinois Mutual	TO A VIEW	1 1 1	
Control (1994) - 1994 (1994) (Klasson	7.22	
Critical Care Protector Plus	- 1		
Combined Insurance			"
			00
Hospital Medical Bridge			
Colonial Life		*	200
Dental			
Delta Dental			
			100
Term Life Insurance			
Illinois Mutual			1000
	197		10
Total:			

o o o o o o o o o o o o o o o o o o o			110
Dental		-	
Delta Dental			0
			100
Term Life Insurance			
Illinois Mutual			1000
	197		(0)
Total:	*		
		<u> </u>	
	1 :		
Pal	do not	72.0	^
EMPLOYEE FIRST AND LAST NAME BOTT	0901 -	orensex	1
REQUIRED ACKNOWLEDGMENT TO PARTICIPA	TE IN FLEXIBLE BENEFITS	PLANS:	
I certify that the features and benefits under the			completely. I
acknowledge that I understand the Important Ir			
the back of this form and agree to be bound by	those requirements and a	iny other requirements o	if the Flexible
Benefits Plan.			
		10	1 1.0
EMPLOYEE'S SIGNATURE B	5	DATE	12:115
GENERAL WAIVER OF PARTICIPATION			
I certify that the features and benefits of the pla	ans listed above have been	explained to me comple	etelv I
understand that these policies are offered throu			
participation in Liberty Classical Academy's bene		in deduction. Thave deci	ded to waive in
participation in Liberty Classical Academy's being	ent onering at this time.		
EMPLOYEE'S SIGNATURE		DATE	
EMPLOYEE'S SIGNATURE		DATE	

- Restrictions on Election Changes: On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a change in status occurs (as defined under the plan and the Internal Revenue Code), and the change is caused by and consistent with the change in status.
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- Use of Personal Information: In addition to and without limiting in any way the rights my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status, and health and dependent child care information) as is reasonably required to administer the plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer; the plan; the service provider; and the respective agents, employees, subcontractors, and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure, or release of such information so long as there is information is used in furtherance of plan administration, or to detect or prevent fraud or misrepresentation.
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N 4st 2015 L			
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Payroll Deductions begin on 11/13/2015			
Short Term Disability			
Illinois Mutual			Dy
Accident		4 2 3 3	×
Illinois Mutual		h.	24
Critical Care Protector Plus			
Combined Insurance	-		DY
Hospital Medical Bridge			
Colonial Life			09
Dental			0
Delta Dental			DY
Term Life Insurance			
Illinois Mutual		19.16	164
Total:		19.16	

Illinois Mutual			24
Critical Care Protector Plus Combined Insurance	2		DY
Hospital Medical Bridge Colonial Life			DY
<u>Dental</u> Delta Dental			Dy
Term Life Insurance Illinois Mutual		19.16	
Total:		19,16	
REQUIRED ACKNOWLEDGMENT TO PARTICIPATE IN FLEXIBLE BENEFITS PLANS: I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. I acknowledge that I understand the Important Information Regarding Participation in the Flexible Benefits Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Flexible Benefits Plan.			
EMPLOYEE'S SIGNATURE 1 James (Grung DATE 10/20/15			
GENERAL WAIVER OF PARTICIPATION I certify that the features and benefits of the plans listed above have been explained to me completely. I understand that these policies are offered through my employer by payroll deduction. I have decided to waive moneration in Liberty Classical Academy's benefit offering at this time.			
EMPLOYEE'S SIGNATURE DATE			

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