



PARTICIPATION FORM – FLEX SPENDING

Plan Year: 1/1/08-12/31/08

Employer: Imperial, Inc.

Employee Name _____

Social Security Number _____

Date of Birth _____

Home Address _____

(Street)

(City)

Home Address _____

(State)

(Zip)

Home phone number _____ Work Phone number _____

Number of pay periods in the plan year _____

(Your annual election will be spread out over the above number of pay periods)

Healthcare Reimbursement (Unreimbursed Medical Expenses) Maximum Election
\$2,500.00 per plan year

I elect to contribute \$ _____ (before taxes) per pay period, which is \$ _____ per plan year, to fund my account for the reimbursement of qualified healthcare expenses not covered under my health and other insurance plans.

Dependent Daycare Reimbursement Maximum election per calendar year is the lesser of (1) \$5,000.00 for married filing joint, or \$2,500 for married filing separate; (2) your spouse's total annual compensation; or (3) ½ of your total compensation. If you are single, the maximum amount is \$5,000.

I elect to contribute \$ _____ (before taxes) per pay period, which is \$ _____ per plan year, to fund my account for the reimbursement of qualified day care expenses.

Decline to participate

I decline to participate in the flexible spending account for the plan year.

Employee signature _____ Date _____

Imperial Coffee Service Election of Medical Reimbursements

NOTE: The annual plan limit which may be allocated to the medical reimbursement account is **\$2,500.00**.

- Reimbursements will be available only for “qualifying medical care expenses.” Generally, “qualifying medical care expenses” are those medical expenses normally deductible on my federal income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- This section of the agreement will automatically terminate if the Plan is terminated or discontinued.
- If I cease my employment with the Employer, my participation in the Plan will cease. No further contributions will be made to the Plan on my behalf, although I may be entitled to reimbursements for claims incurred prior to my date of termination.
- I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction or credit on my tax return.

Imperial Coffee Service Election of Dependent Care Assistance

I understand that:

- Reimbursement will be available only for “qualifying dependent care expenses” as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.
- I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred.
- I agree to provide the Administrator with the name, address, and if applicable, the Tax identification number of the service provider.
- This section of the agreement will automatically terminate if the Plan is terminated or discontinued. I will, however, be entitled to be reimbursed for eligible expenses (to the extent funded) for the remainder of the Plan Year.
- I will only be reimbursed for amounts up to the balance in my account at the time of my request.
- I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care assistance program.

**Imperial Coffee Service
Other Terms and Conditions**

I understand that:

- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the Plan Year unless I have a change in status and my election is consistent with such change.
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my Employer.
- Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later Plan Year.
- Prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit elections for the following Plan Year.

This agreement is subject to the terms of the Employer's Cafeteria Plan, as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such Plan.

_____ Date _____
Employee's Signature

Accepted and agreed to by the Employer's
Authorized Representative.

By: _____ Date _____