I and my employer agree that my pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected under the Preferred Blue Account, and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution for each benefit option is set forth below.

**PREFERRED BLUE ACCOUNTS**

**Health FSA**

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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
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</table>

Deduction per pay period: ___________________________
Payroll Frequency: _____________________________
Annual Election Amount: _____________________________

**Dependent Care Account**

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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
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</table>

Deduction per pay period: ___________________________
Payroll Frequency: _____________________________
Annual Election Amount: _____________________________

The terms of the Preferred Blue Accounts under the Section 125 Cafeteria Plan have been explained to me and I have read the descriptive material. I understand my options with regards to elections made under it. I hereby elect the benefits as indicated above and agree to have the pre-tax benefits purchased as an employer contribution on my behalf. I understand that by signing and submitting this enrollment form, that the benefits above will remain in effect for the entire plan year and that this election cannot be revoked or changed during the plan year, unless there is a change in family status (i.e., marriage, divorce, death of a spouse, birth or adoption of a child or termination of employment of a spouse).

**FOR REFUSAL ONLY**

This plan has been explained to me and I choose not to participate this year.

**BlueCross BlueShield of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association