

**LEWIS UNIVERSITY  
RESTATED AND AMENDED CAFETERIA PLAN  
AND  
DEPENDENT CARE ASSISTANCE PLAN**

Election of Dependent Care Assistance and  
Compensation Reduction Agreement

Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_

I elect to receive dependent care assistance for the following Plan year (July 1 to June 30):

Amount of compensation reduction for the year (Not to exceed the limitation in Paragraph 8 on Qualifying Dependent Care Expenses attachment).

If the amount elected in the preceding sentence exceeds \$2,500 for the plan year, I certify that :

- I will file a joint Federal income tax return with my spouse for the year; or
- I am not married.

I and Lewis University hereby agree that my cash compensation will be reduced by the amount set forth above, in approximately equal installments for each pay period, during the above Plan year (or during such portion of the year as remains after the date of this agreement).

I understand that:

- The amount of my compensation reduction for each pay period during the year will be credited to a dependent card assistance account for the year on the books of the University, and I will be reimbursed, up to the balance in that account, for my dependent care expenses incurred during the year.
- Reimbursement will be available only for qualifying dependent care expenses described on the attachment to this form, I agree to notify the University if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying dependent care expense. I also agree on demand to indemnify and reimburse the University for any liability it may incur for failure to withhold federal and state 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 cannot change or revoke this compensation reduction agreement at any time during the Plan year unless the change or revocation is on account of and consistent with a change or revocation is on account of and consistent with a change in my family status, (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse, and such other events as the Plan Administrator determines will permit a change or revocation).
- This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the University which, before reduction here under, is at least equal to twice the amount of that reduction.
- The Plan Administrator may reduce or cancel my compensation reduction, limit my reimbursements, or otherwise modify this agreement in the event the Administrator 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 plans.

This agreement is subject to the terms of the Lewis University Restated and Amended Cafeteria Plan and Dependent Care Assistance Plan as from time to time in effect, shall be governed by and construed in accordance with the laws of Illinois, shall take effect as a sealed instrument under the laws of Illinois, and revokes any prior election and compensation reduction agreement relating to the Dependent Care Assistance Plan.

\_\_\_\_\_  
Employee's signature

Date:

Accepted and agreed to by Lewis University

By:\_\_\_\_\_

Date: