IPG SERVICES CORP.

FLEXIBLE BENEFIT PLAN

Enrollment and Account Election Form – Plan Year: 7/1/06 to 6/30/07

Name ______________________________ SS# ________ - ______ - ________
First   Middle Initial   Last

Address ____
Street   City   State   Zip Code

Phone: Work (   ) ________________ Home (   ) ________________

❑ ***Check box if address has changed from previous year.***

Date of Birth: ________________ Age ________ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced

OFFICE USE ONLY

Date of Hire ____________

Effective Date ____________

PPN # ____________

Salary ____________

Pre-tax ded. ____________

After-tax ded. ____________

BENEFIT SELECTIONS: Check *Coverage* desired, and enter *Your Weekly Cost* in this column:

1

Employee Life Insurance and Accidental Death & Dismemberment (Hartford)

Choose **Core Benefit *or* an Option**

Core Benefit — **Your Cost**

❑ $10,000 — **0.00**

or

Choose **an Option (includes Core above)**

- ❑ $50,000 .... **2.65**
- ❑ $75,000 .... **4.30**
- ❑ $100,000 .... **6.00**
- ❑ $150,000 .... **9.25**
- ❑ $200,000 .... **12.00**

On future annual enrollments, employees may buy up one level to the plan guarantee issue amount. Any amount in excess of one level or the guarantee issue (up to the plan maximum) will be subject to evidence of insurability (proof of good health). (ADEA Age Reduction 35% at age 65, 50% of the original amount at age 70). Value of Life Insurance in excess of $50,000 is taxable income to you.

BENEFICIARY(S): Please name a beneficiary(s) for your Life Insurance and Accidental Death & Dismemberment election:

____
(First)   (Middle Initial)   (Last)   (Relationship)   %   (Primary or Secondary)

____
(First)   (Middle Initial)   (Last)   (Relationship)   %   (Primary or Secondary)

Multiple beneficiaries will be considered equal unless designated as: Primary (1) or Secondary (2).

Suicide Exclusion: No supplemental Life benefit will be payable if death results from suicide, whether sane or insane, within 24 months/2 years of the effective date of coverage. Additionally, if death results from suicide whether sane or insane, within 24 months/2 years of the effective date of an increase in coverage, the death benefit payable is limited to the amount of coverage in force prior to the increase. The 24 month/2 year period mentioned above will include the period of time coverage was in force under a Prior Plan.

1

Enter YOUR Weekly Cost

$ __________

2

Large Amount Accidental Death & Dismemberment (Hartford) *FOR ACCIDENTS ONLY*

Choose **None *or* an Option**

Your Cost

❑ **None** — **0.00**

or

Choose **an Option**

Single Coverage		**Family Coverage**	
❑ $100,000 employee only	**1.35**	❑ $100,000 ee, $50,000 spouse, $10,000 children	**1.85**
❑ $150,000 employee only	**2.10**	❑ $150,000 ee, $75,000 spouse, $15,000 children	**2.85**
❑ $200,000 employee only	**2.60**	❑ $200,000 ee, $100,000 spouse, $20,000 children	**3.60**

(This benefit is available for dependent children age 14 days – 19 years and spouses to age 70.)

2

Enter YOUR Weekly Cost

$ __________

TOTAL FOR PAGE 1: *(Add boxes 1-2)* ⇨ $__________

BENEFIT SELECTIONS: Check *Coverage* desired, and enter *Your Weekly Cost* in this column: ↓

3 Short Term Disability (BCI Administrators, Inc.)

***Choose* None *or* an Option**

	Your Cost
❑ **None**	**0.00**

or

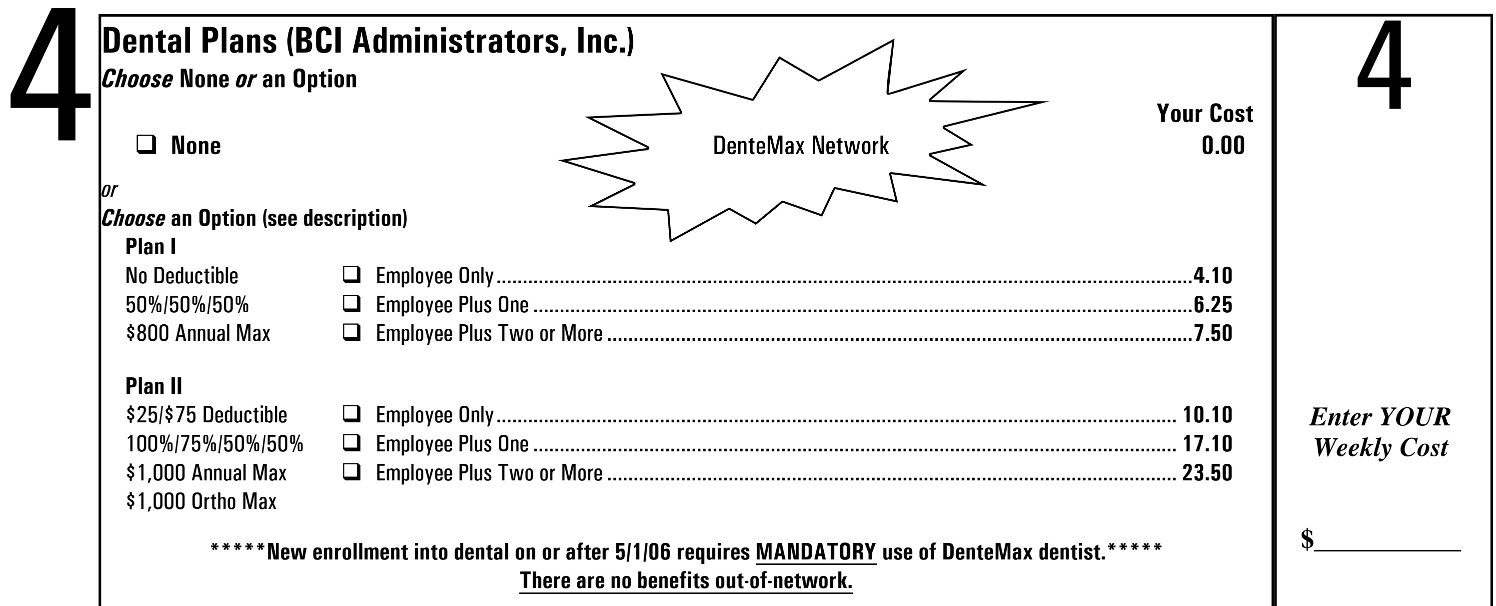
Choose an Option

Option	Your Cost
❑ 60% of weekly income to a maximum of $100	3.50
❑ 60% of weekly income to a maximum of $200	5.50
❑ 60% of weekly income to a maximum of $300	7.50
❑ 60% of weekly income to a maximum of $400	9.50
❑ 60% of weekly income to a maximum of $500	11.50

(Benefits start on the 8th day for an accident or the 8th day for an illness for a maximum of 26 weeks.)

TO ENROLL YOU MUST HAVE COMPLETED 1 YEAR (12 FULL MONTHS) OF SERVICE PRIOR TO JULY 1, 2006.

3 — *Enter YOUR Weekly Cost* $___________



4 Dental Plans (BCI Administrators, Inc.)

***Choose* None *or* an Option**

	Your Cost
❑ **None**	**0.00**

or

***Choose* an Option (see description)**

Plan	Coverage	Your Cost
Plan I		
No Deductible	❑ Employee Only	4.10
50%/50%/50%	❑ Employee Plus One	6.25
$800 Annual Max	❑ Employee Plus Two or More	7.50
Plan II		
$25/$75 Deductible	❑ Employee Only	10.10
100%/75%/50%/50%	❑ Employee Plus One	17.10
$1,000 Annual Max	❑ Employee Plus Two or More	23.50
$1,000 Ortho Max		

*******New enrollment into dental on or after 5/1/06 requires MANDATORY use of DenteMax dentist.*******
There are no benefits out-of-network.

4 — *Enter YOUR Weekly Cost* $___________

5 Health Plans (M-Care)

***Choose* None *or* an Option**

	Your Cost
❑ **None**	**0.00**

Opt out ONLY with proof of coverage elsewhere. Attach a copy of I.D. card to form.

or

***Choose* an Option**

Plan	Coverage	Your Cost
M-Care Low Option	❑ Employee Only	20.75
HMO Plan	❑ Employee Plus One	61.00
$20 Office Visit Copay	❑ Employee Plus Two or More	82.75
$500/$1,000 Deductible		
$10/$40 Rx Card, MOPD 2X		
M-Care High Option	❑ Employee Only	25.45
HMO Plan	❑ Employee Plus One	74.80
$20 Office Visit Copay	❑ Employee Plus Two or More	101.50
No Deductible/$75 ER Copay		
$15/$25 Rx Card, MOPD 2X		
M-Care PPO Plan	❑ Employee Only	29.70
90%/80% Coinsurance	❑ Employee Plus One	86.90
$20 Office Visit Copay	❑ Employee Plus Two or More	118.00
$250/$500 Deductible		
$10/$40 Rx Card, MOPD 2X		

5 — *Enter YOUR Weekly Cost* $___________

TOTAL FOR PAGE 2: *(Add boxes 3-5)* ⇨ $___________

6

Vision Care (BCI Administrators, Inc.)

Choose **None *or an* Option**

		Your Cost
❑ **None**		**0.00**
or		
Choose an **Option** (see description)	❑ Employee Only	**1.60**
	❑ Employee Plus One	**3.00**
	❑ Employee Plus Two or More	**4.00**

6

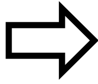
Enter YOUR Weekly Cost

$__________

TOTAL FROM PAGE 3: ⇨ $__________

TOTAL FROM PAGE 2: ⇨ $__________

TOTAL FROM PAGE 1: ⇨ $__________



Total Weekly Pre-Tax Benefit Cost to You:
(Add totals from Pages 1, 2 and 3)

$____________________

Pre-Tax Flexible Spending Account Salary Reduction Options: (Extended Grace Period 7/1/06—9/15/07)

If you choose, you can elect to deposit additional money on a pre-tax basis into either a medical reimbursement account, a dependent care account or both. The money may not be mixed between the two accounts. The choice can only be made once each plan year and cannot be changed except in the event of a qualified status change. For details regarding specific status changes, please see your Summary Plan Description. At the end of the grace period, any money not used must, by law, be forfeited.

I elect to reduce my weekly wages and put the money into the following accounts:

❑ **Medical Reimbursement Account**

$ ______ per weekly pay period, Minimum amount is $5.00; Maximum amount is $38.46 based on a full plan year ($2,000 per year)

❑ **Dependent Care Reimbursement Account***

$ ______ per weekly pay period, Minimum amount is $5.00; Maximum amount is $96.15 based on a full plan year ($5,000 per year)

****You must also complete the Dependent Care Assistance Plan Authorization Form in order to participate in a dependent care reimbursement account.***

Dependent Life Insurance (Hartford)

Choose **None *or* an Option**

This benefit is available for dependent children 14 days – 23 years and spouses to age 70.
This benefit is not part of the Flexible Benefit Plan. Amounts below are after tax.

	Your Cost
❑ **None**	**0.00**
or	
Choose an **Option**	
❑ $5,000 on spouse and $2,000 on children	**0.45**
❑ $10,000 on spouse and $4,000 on children	**1.00**
❑ $15,000 on spouse and $6,000 on children	**1.75**

Note: If your spouse or dependent child is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days.

Enter YOUR Weekly After-Tax Cost

$__________

Enrollment/Coordination of Benefits Information:

List those individuals to be covered under the Vision, Dental or Health Plans.
NOTE: You may only cover legally married spouses, and children to age 19 or to age 25 if full-time student.

	LAST NAME	FIRST	M.I.	SEX	SS#	BIRTHDATE	AGE	VISION	DENTAL	HEALTH
EMPLOYEE										
SPOUSE										
CHILD										
CHILD										
CHILD										
CHILD										
CHILD										
CHILD										

Are you covered by any other Group Vision Plan? ❑ Yes ❑ No or Dental? ❑ Yes ❑ No or Health? ❑ Yes ❑ No

Is your spouse covered by any other Group Vision Plan? ❑ Yes ❑ No or Dental? ❑ Yes ❑ No or Health? ❑ Yes ❑ No

Are your children covered by any other Group Vision Plan? ❑ Yes ❑ No or Dental? ❑ Yes ❑ No or Health? ❑ Yes ❑ No

If you answered Yes to any of the above questions, please complete the following:

Insured's Name____________________ Social Security #________________ Date of Birth____________

Name of other Insurance Company or Third Party Administrator:____________________ Group # ____________

Employer providing other coverage:________________________________

Benefits provided by other coverage:________________________________

NOTE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you wish to add a new dependent or terminate coverage as a result of a change in family status, such as marriage, birth, adoption, or placement for adoption, you may be able to do so, provided that you request enrollment/termination within 30 days after the qualified status change. We will require proof of this other coverage. If you do not supply proof, you will be denied these special enrollment rights.

IMPORTANT!

If any dependent listed above is covered under the Health, Dental or Vision plan, and does not reside at the address shown on Page 1 of this form, please provide their current address below:

Name **Current Address**

____

Signature/Authorization

While every effort has been made to assure accuracy in the plan definitions on this form, I understand that this is strictly an election form. The contracts that my employer has signed with the insurance carriers and plan documents will be binding. I understand that this election may not be changed during the plan year unless I have a qualified status change and that unused allocations, if any, by law, will be forfeited according to the plan documents. I authorize my employer to reduce my wages by the amounts required (if needed) to pay for the Flexible Benefit Options I have elected. My signature below acknowledges my elections on pages 1, 2, 3 and 4.

Signature________________________________ Date________________