PLAN ADMINISTRATOR OVERRIDE FORM

I (Name:), _____ the (Title:) _____

of (Company Name:) _____ ("Company"), hereby exercise the authority

of the plan sponsor and plan administrator of the (Plan Name:) _____

Plan ("Plan") with regard to the payment of claims under the Plan, and hereby direct AmeriFlex to pay the

following claim or claims:

Description of Expense (including the amount): _____

Date of Expense: _____

Plan Participant: _____

Participant SSN/Employee ID #: _____

Covered Person: _____

NOTE: ALL OF THE ABOVE MUST BE FILLED OUT COMPLETELY FOR AMERIFLEX TO PROCESS THE CLAIM(S) IN QUESTION.

****PLEASE INITIAL ALL DESIGNATED SPACES****

_____I acknowledge that a duly authorized representative of AmeriFlex has advised the Company that, in the opinion of AmeriFlex, the reimbursement of this claim may not be allowable under the Internal Revenue Code and/or the rules, regulations, and courts' decisions promulgated thereto.

_____I acknowledge that, notwithstanding the foregoing, the Company is mandating the payment of this claim or similar claims to this participant.

_____I attest that the Company will hold AmeriFlex and its employees harmless and will fully indemnify AmeriFlex for the payment of this claim or similar claims to this participant.

Signature **Date**