Change in Status Election Form

For Lilly Enterprises Inc
Section 125 Premium Only Plan
Plan Year January 1, 2025 through December 31, 2025

Employee Name: _____

Employee Address: _____

Employee Number: _____

As a participant in the Premium Only Plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status.

I understand that the change in my benefit election must be necessitated by and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury.

I certify that I have incurred the following change in status:

___ Marriage.

___ Divorce, Legal Separation, or Annulment.

___ Birth, or adoption, or placement for adoption of a child.

___ Death of my spouse and/or dependent.

___ Termination or commencement of employment by my spouse or dependent.

___ A judgment, decree, or order ("order") that affected eligibility for benefits.

___ I, my spouse, or dependent have had a change in employment status, including switching from part-time to full-time (or vice versa) or reduction or increase in hours a strike or lockout, that affected eligibility for benefits.

___ A change in the residence or worksite of myself, my spouse, or dependent that affected eligibility for benefits.

___ I, my spouse, or dependent have taken an unpaid leave of absence that affected eligibility for benefits.

___ My dependent satisfies or ceases to satisfy the requirements for coverage's due to attainment of age, student status, or any similar circumstance.

___ A cost or coverage change in benefits that affected eligibility for me, my spouse, or dependent.

___ Eligibility for coverage during open enrollment or a Special Enrollment Period of a Marketplace Qualified Health Plan (QHP).

___ Moving from full-time status (at least 30 hours of service per week) to part-time status (less than 30 hours per week), even if the reduction in hours does not result in your ceasing to be eligible under the group health plan.

___ A change made under my spouse's or dependent's employer benefits plan if the election for a period of coverage for my Plan is different from the period of coverage (open enrollment) under the other cafeteria plan or qualified benefits plan.

___ I, my spouse or dependent who has been entitled to Medicaid or Medicare coverage lost eligibility. That individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

The Administrator may require you to provide evidence to document the event which requires the change of election.

By _____ Date_____

Employee's signature

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

By _____ Date_____

Administrator's signature

Eleccion de participar

Por Lilly Enterprises Inc
Premium Only Plan Seccion 125
Afio del plan January 1, 2025 hasta December 31, 2025

Nombre de empleado: _____

Como empleado elegible en el plan anterior, reconozco que he recibido la Descripcion resumida de! plan. He leido la Descripcion resumida de! plan y comprendo los beneficios disponibles para mi, asi como los demas derechos y obligaciones que tengo en virtud del Plan.

De acuerdo con mis derechos en virtud del Plan, elijo los siguientes beneficios que he seleccionado para el afio del plan especificado anteriormente. El Empleador y yo acordamos que mi remuneracion en efectivo sera redireccionada por los importes establecidos a continuacion para cada periodo de pago y afio del plan (o durante la parte del afio que quede despues de la fecha de este acuerdo).

En el (los) formulario(s) de inscripcion de beneficios correspondientes, me he inscrito para determinada(s) cobertura(s) de seguro. Elijo recibir la siguiente cobertura del Premium Only Plan:

- **Planes de seguro medico**
- **Seguro de vida colectivo a termino**
- **Planes de discapacidad.** Si se paga antes de impuestos, cualquier beneficio futuro recibido estara sujeto a impuestos para el empleado.
- **Cuenta de Ahorros para la Salud (HSA).** Le permite, mediante deducciones de nomina, realizar contribuciones a su plan HSA individual con do1ares antes de impuestos. El monto aportado se establecera en un formulario de solicitud de HSA separado proporcionado por mi administrador de HSA, en su caso.

Entiendo que:

- En lugar de importes especificos en dolares, por la presente elijo la(s) cobertura(s) de seguro especificada(s) anteriormente y autorizo a redireccionar salario en los importes de las primas actuales que se cobran.
- Si mis contribuciones necesarias para pagar las primas por los beneficios elegidos aumentan o disminuyen mientras este acuerdo permanece en vigencia, el redireccionamiento de mi remuneracion se ajustara automaticamente para reflejar ese aumento o disminucion.
- No puedo cambiar ni revocar ninguna de mis elecciones o este acuerdo de redireccionamiento de salario en ningun momento durante el Afio del plan (con la excepcion de la HSA) a menos que tenga un "cambio de estado" y el cambio de eleccion sea coherente con el "cambio de estado." Esto significa: matrimonio , el divorcio, la muerte de un conyuge o un hijo , el nacimiento o la adopcion de un hijo , la terminacion o el comienzo del empleo de un conyuge, el cambio en mi situacion laboral o la de mi conyuge de tiempo completo a tiempo parcial o de tiempo parcial a tiempo
- completo, que mi conyuge o yo tomemos una licencia sin goce de sueldo, un cambio sustancial en la cobertura de salud de mi familia debido a un cambio en la cobertura de salud patrocinada por el empleador de mi conyuge, la inscripcion abierta en el mercado u otros acontecimientos que el Administrador del plan determine que permita cambiar o revocar una eleccion.
- Tambien puede cambiar su eleccion durante la inscripcion abierta y los Periodos de inscripcion especial de un Plan de salud calificado del Mercado (QHP) y si se cambia de un estado de tiempo completo (al menos 30 horas de servicio por semana) a un estado de tiempo parcial (menos de 30 horas por semana), incluso si la reduccion de horns no implica que deje de ser elegible para el plan de salud grupal; y busca cobertura en otro plan que proporcione una cobertura esencial minima.
- El Administrador del plan puede redireccionar o cancelar el redireccionamiento de mi remuneracion o modificar este acuerdo en el caso de quelo crea conveniente para cumplir con ciertas disposiciones del Codigo de [mpuestos Internos.
- El redireccionamiento de mi remuneracion en efectivo conforme a este acuerdo sera adicional a cualquier reduccion en virtud de otrosacuerdos o programas de beneficios mantenidos por mi Empleador.
- Cualquier monto que nose utilice durante un Afio de! plan para proporcionar beneficios se perdera y nose me podra pagar en efectivo ni utilizar para brindar beneficios especfficamente para mi en un Aiio de! plan posterior. Las contribuciones a mi HSA no estan sujetas a confiscacion.
- Antes de! primer dia de cada Ano del plan, se me ofrecera la oportunidad de cambiar mi eleccion de beneficios para el siguiente Afio de! plan. Si no completo y devuelvo un nuevo fonnulario de eleccion en ese momento, se considerara que no he elegido continuar con mis elecciones de beneficios para el nuevo Afio de! plan.
- Si el seguro de discapacidad se paga antes de impuestos, cualquier beneficio que reciba puede estar sujeto a

  impuestos. Al jubilanne, mis beneficios de la Seguridad Social pueden reducirse levemente.

Este Acuerdo esta sujeto a los terminos de! Premium Only Plan de! Empleador, con sus ocasionales modificaciones, se regira e interpretara de acuerdo con las leyes aplicables, entrara en vigor como un instrumento sellado segun las leyes aplicables y revoca cualquier eleccion anterior y acuerdo de redireccionamiento de la remuneracion relacionado con dicho Plan.

Por_____ Fecha_____

Firma de! Empleado

Aceptado y acordado por el Representante autorizado de! Empleador

Por _____ Fecha_____

Finna del Administrador

Election NOT to Participate

For Lilly Enterprises Inc
Section 125 Premium Only Plan
Plan Year January 1, 2025 through December 31, 2025

Employee Name: _____

I understand all the benefit options available under the Premium Only Plan.

I elect NOT to participate in the Premium Only Plan and instead to receive my full compensation in cash. You will receive the full amount of your salary or other compensation without reduction for benefits available, or any reduction on applicable employment tax costs.

As an eligible employee in the above plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

I understand that:

- I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the Plan Year (with the exception of the HSA) unless I have a "change in status" and the election change is consistent with the "change in status", (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage, Marketplace open enrollment or such other events as the Plan Administrator determines will permit a change or revocation of an election).
- Prior to each Plan Year I will be offered the opportunity to change my benefit election for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my election to receive full cash compensation in effect for the new Plan Year.

By _____ Date _____
Employee's signature

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

By _____ Date _____
Administrator's signature

Eleccion de NO participar

Por Lilly Enterprises Inc
Premium Only Plan Seccion 125
Ano del plan January 1, 2025 hasta December 31, 2025

Nombre de empleado_____

Entiendo todas las opciones de beneficios disponibles bajo el Premium Only Plan.

Elijo NO participar en el Premium Only Plan y, a cambio, recibir mi remuneracion completa en efectivo. Recibira el monto total de su salario u otra retribucion sin reduccion por beneficios disponibles, o cualquier reduccion sobre los costos de impuestos laborales aplicables.

Como empleado elegible en el plan anterior, reconozco que he recibido la Descripcion resumida del plan. He leido la Descripcion resumida del plan y comprendo los beneficios disponibles para mi, asi como los demas derechos y obligaciones que tengo en virtud del Plan.

Entiendo que:

- No puedo cambiar ni revocar ninguna de mis elecciones o este acuerdo de redireccionamiento de remuneracion en ningun momento durante el Afio del plan (con la excepcion de la HSA) a menos que tenga un" cambio de estado" y el cambio de eleccion sea coherente con el "cambio de estado", (incluido el matrimonio , el divorcio , la muerte de un conyuge o un hijo , el nacimiento o la adopcion de un hijo , la terminacion o el comienzo del empleo de un conyuge, el cambio en mi situacion laboral o la de mi conyuge de tiempo completo a tiempo parcial o de tiempo parcial a tiempo completo, que mi conyuge o yo tomemos una licencia sin goce de sueldo , un cambio sustancial en la cobertura de salud de mi familia debido a un cambio en la cobertura de salud patrocinada por el empleador de mi conyuge , la inscripcion abierta en el mercado u otros acontecimientos que el Administrador del plan determine que permita cambiar o revocar una eleccion).
- Antes de cada Afio del plan, se me ofrecera la oportunidad de cambiar mi eleccion de beneficios para el siguiente Afio del plan. Si no completo y devuelvo un nuevo formulario de eleccion en ese momento, se considerara que he elegido continuar con mi eleccion de recibir la remuneracion completa en efectivo vigente para el nuevo Afio del plan.

Por_____ Fecha_____
Firma del Empleado

Aceptado y acordado por el Representante autorizado del Empleador

Por_____ Fecha_____
Firma del Administrador

Election to Participate

For Lilly Enterprises Inc
Section 125 Premium Only Plan
Plan Year January 1, 2025 through December 31, 2025

Employee Name: _____

As an eligible employee in the above plan, I acknowledge that I have received the Summary Plan Description. I have read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

In accordance with my rights under the Plan, I elect the following benefits I have selected for the plan year specified above. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for each pay period and plan year (or during such portion of the year as remains after the date of this agreement).

On the appropriate benefit enrollment form(s), I have enrolled for certain insurance coverage(s). I elect to receive the following coverage under the Premium Only Plan:

- **Health Insurance Plans**
- **Group-Term Life Insurance**
- **Disability Plans.** If paid for on a pre-tax basis, any future benefits received will be taxable to the employee.
- **Health Savings Account (HSA).** Allows you to make contributions through payroll deduction to your individual HSA plan with pre-tax dollars. The amount contributed shall be established on a separate HSA application form provided by my HSA Trustee, if applicable.

I understand that:

- In lieu of specific dollar amounts, I hereby elect the above specified insurance coverage(s) and authorize salary redirections in the amounts of current premiums being charged.
- If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation redirection will automatically be adjusted to reflect that increase or decrease.
- I cannot change or revoke any of my elections or this compensation redirection agreement at any time during the Plan Year (with the exception of the HSA) unless I have a "change in status" and the election change is consistent with the "change in status." This means: marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or me taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage, Marketplace open enrollment or such other events as the Plan Administrator determines will permit a change or revocation of an election.
- You may also change your election during open enrollment and Special Enrollment Periods of a Marketplace Qualified Health Plan (QHP) and if you are moved from full-time status (at least 30 hours of service per week) to part-time status (less than 30 hours per week), even if the reduction in hours does not result in your ceasing to be eligible under the group health plan; and you seek coverage in another plan that provides minimum essential coverage.
- The Plan Administrator may redirect or cancel my compensation redirection or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The redirection 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. Contributions to my HSA are not subject to forfeiture.
- 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. If I do not complete and return a new election form at that time, I will be treated as having not elected to continue my benefit elections for the new Plan Year.
- If disability insurance is paid for on a pre-tax basis, any benefits I receive may be taxable.
- Upon retirement, my Social Security benefits may be slightly reduced.

This Agreement is subject to the terms of the Employer's Premium Only 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 redirection agreement relating to such Plan.

By _____ Date _____

Employee's signature

Accepted and agreed to by the Employer's Authorized Representative

By _____ Date _____

Administrator's signature

Revocation of Benefit Election Form

For Lilly Enterprises Inc
Section 125 Premium Only Plan
Plan Year January 1, 2025 through December 31, 2025

Employee Name: _____

Effective_____, I hereby revoke my benefit election and compensation redirection agreement under the Premium Only Plan with respect to the following benefit coverage(s): (Please check and fill in the appropriate options.)

- _____
- _____
- _____
- _____
- _____

My benefit election and compensation redirection agreement shall remain in effect as to my benefit coverage's, if any, which are not listed above.

By _____ Date _____
Employee's signature

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

By _____ Date _____
Administrator's signature

This revocation may not be effective prior to the first day of the next Plan Year unless it is made because of a change in status as defined in the Plan. In no event may the revocation be effective prior to the first pay period beginning after this form is completed and returned to the administrator of the Plan, unless otherwise required by Code Section 9801(f) to be retroactive. You can revoke the Health Savings Account at any time