Benefit Plan Adoption Agreement

Section 1

Last Name:	Woodard	First Name:	Norma
Business Name:	EagleView Consulting, Inc.	Email Address:	eagleviewn@cox.net
Phone Number:	405-390-2248	Fax Number:	866-297-9087
Address:	PO Box 146	City:	Choctaw
State:	OK	Zip Code:	73020

Section 2

Business Type: C-Corp Employer ID Number: 731594720

The plan year shall be a 12-consecutive month period, or, in the case of the first plan year, a shorter period.

Plan administrator shall be: Norma Woodard

Do you own controlling interest in any other business? No

Section 3

Employees may participate in the plan if:

The employee works the required hours in a week:	20 hours
The employee works more than the required months:	7 months per year
The employee meets the required age:	25 years of age
They are current employees and have worked:	0 months
They are new employees and have worked at least:	12 months

The following employee(s) meet the above requirements:

Norma Woodard

Section 4

The following qualified medical expenses will be reimbursed:

Health Insurance Premiums:	ALL
Qualified Long Term Care Premiums:	ALL
Other Accident Health Premiums:	N/A
Term Life Insurance Premiums:	N/A
Disability Insurance Premiums:	N/A
Out-of-Pocket Medical Expenses:	Yes Limit: $10,000
Carry Over Feature:	Yes Limit: None

Section 5

Term Life Insurance Premiums and Disability Insurance Premiums that are elected reimbursements under the Plan are benefits reserved solely for the Employee/Participant and are not extended to, or available for, the Participant's spouse or dependents. Additionally, Term Life Insurance Premiums are subject to further discrimination rules.

Section 6

The Company agrees to execute a new or amended Adoption Agreement, if necessary, in order to maintain compliance with Section 105 of the Code. The Company hereby agrees that by adoption of the Plan, it has assumed full responsibility for the legal effect and tax consequences of the Plan and is solely responsible for reporting and disclosure requirements to the Internal Revenue Service, the Department of Labor, and Plan Participants.

Section 7

The Company hereby adopts an accident and health plan within the meaning of Section 105 of the Internal Revenue Code of 1986 ("the Code"), as amended, subject to all of the terms and conditions thereof, and conforms to the information placed in Section 2 of this document.

NOTE: Ordinarily, the Company is designated as the Plan Administrator. The Administrator is a "named fiduciary" with respect to the Plan, and has substantial fiduciary responsibilities under the terms of the Plan and under the law.

Section 8

Eligible employees: Employees of the Company who customarily work both the hours per week required, and the months per year required, under Section 3 are eligible to participate in the Plan. The following classes of employees are not eligible for the Plan:

(a) Members of a bargaining unit covered by a collective bargaining agreement, provided the Company has bargained in good faith on the subject of accident and health benefits;

(b) Nonresident aliens who receive no U.S.-source income from the company for the Plan year.

An eligible employee becomes a Participant in the Plan, if on the effective date, he or she meets the age requirement and has completed the required months of continuous service with the Company. Otherwise, an eligible employee becomes a Participant as of the first of the month after meeting the eligibility requirements.

The Company understands and agrees that, of the foregoing numbered or lettered items or portions thereof which have boxes to be checked, only those that are checked and, where required, completed, shall be considered as provisions applicable to forming part of the Plan. The accompanying 105 Concepts Medical Expense Reimbursement Plan Document is incorporated herein by this reference and together with the Benefit Plan Adoption Agreement forms the Plan established hereunder.

Section 9

No Participant shall be entitled to receive more than the maximum amount in reimbursements under the Plan for any Plan Year. For this purpose, amounts received that are attributable to reimbursements due the Participant's spouse or dependents shall be considered to have been received by the Participant.

Section 10

Annual Plan Fee:

Employer Signature ______________________________ Date ___/___/______

HRA Representative: Norma Woodard

Monthly Reimbursement Form
EagleView Consulting, Inc.

Month: ______________________

Name:	______________________		
Address:	______________________		
City:	______________________	State:	_____
Zip Code:	______________	Phone Number:	__________________

Premiums

Insurance Type	**Company** *(List all carriers for plan month)*	**Total Premiums Paid** *(During plan month)*
Health	__________________________	$___________.___
Disability	__________________________	$___________.___
Long Term Care	__________________________	$___________.___
Other Premiums *(Cancer, Term Life, Accident, etc.)*	__________________________	$___________.___
	Premium Total:	$___________.___

Out-of-Pocket

Type of Expense	**Service Provider**	**Date of Service**	**Total Expenses**
___________	______________________	___/___/______	$ __________.___
___________	______________________	___/___/______	$ __________.___
___________	______________________	___/___/______	$ __________.___
___________	______________________	___/___/______	$ __________.___
___________	______________________	___/___/______	$ __________.___
		Out-of-Pocket Total:	$ __________.___