

ENROLLMENT FORM for the FLEX BENEFITS PLAN

PLEASE PRINT. All information is required or your enrollment cannot be processed.

Employer _____

Employee Name (First, Last) _____

Social Security Number _____ - _____ - _____ Date of Birth (MM-DD-YYYY) _____ - _____ - _____

Home (Street) Address _____ Apt. _____

City _____ State _____ Zip _____

Home Phone _____ - _____ - _____ E-mail _____

Employer to complete or enrollment cannot be processed. Plan year start (mm/dd/yy) ____/____/____ and end ____/____/____
First payroll start date ____/____/____. No. of Pays _____.

OPTION 1 HEALTH CARE ACCOUNT – FLEXIBLE SPENDING ACCOUNT (FSA)

YES – I elect to contribute \$ _____ (before taxes) for the PLAN YEAR, which is \$ _____ per pay period to fund my account that pays qualified out-of-pocket healthcare expenses that are not covered by my employer's health plan or any other health plan.

NO – I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 2 DEPENDENT CARE ACCOUNT

This pays for daycare expenses for a dependent child, adult or elder, so that you may work. Eligible services include: nursery school, nanny and/or before/after school care through age 12, day care for a disabled adult or child, elder daycare for parent or dependent, day camp through age 12.

YES – I elect to contribute \$ _____ (before taxes) for the PLAN YEAR, which is \$ _____ per pay period to fund my account that pays qualified dependent day care of elder care expenses.

NO – I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

YOU MAY ENROLL IN THE FOLLOWING BENEFITS ONLY IF THEY ARE OFFERED BY YOUR EMPLOYER. Check your Summary Plan Description or ask your employer.

OPTION 3 AGREEMENT TO SAVE TAXES ON INSURANCE PREMIUMS

YES – On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance). I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

	Salary Reduction Amount Per Pay Period	No. of Reductions Per Year
Group Medical	_____	_____
Dental Coverage	_____	_____
Short Term Disability	_____	_____
Cancer	_____	_____
Vision	_____	_____
Accident	_____	_____
Other	_____	_____

OPTION 4 DEBIT CARD

YES – I would like a debit card for my account. There is an annual charge of \$ _____. The fee will be deducted from your Flex Account.

Spouse or Dependent's full name for 2nd take care flex benefits card (First, Last) _____

NO – I decline the option of a debit card for my account.

IMPORTANT – Please read the following before signing this enrollment form. My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections (Options 1 through 4) set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I understand that the take care flex benefits card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I understand that when using the flex benefits card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

IMPORTANT: Cosmetic and elective procedures are not eligible for reimbursement. Please note, vitamins and supplements require a letter of medical necessity from your doctor. Employee website for account balance and claims information — www.myflexonline.com.

Employee signature _____

Date _____