ENROLLMENT FORM FOR THE take care® 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) _____ Date Hired (MM-DD-YYYY) _____

Home (Street) Address _____ APT. _____

City _____ State _____ Zip _____

Home Phone _____ Email _____

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

OPTION 1A 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 health care 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 1B LIMITED FLEXIBLE SPENDING ACCOUNT (LFSA)

Available only if you elect to enroll in an HSA(Health Savings Account).

☐ **YES** I elect to contribute $_____ *(before taxes)* for the PLAN YEAR, which is $_____ per pay period to fund my account that pays only qualified dental and vision 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 day care 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 day care 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 or 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.

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.

☐ **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.

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status. 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. Any qualified expenses that are submitted by me will be reimbursed to me on a tax free basis. Generally any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge that I have received, read and understand the Summery Plan Description.

Employee signature _____ Date _____

RETURN COMPLETED FORM TO YOUR EMPLOYER