take care® Commuter Benefits Plan

Enrollment Form

take care® by WageWorks

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

Employer _____ Social Security Number

Employee Name (First, Last)

Date of Birth (MM-DD-YYYY) Date Hired (MM-DD-YYYY)

Home (Street) Address APT.

City State Zip

Home Phone Email _____

By enrolling in the plan you will receive a take care® Flex Benefits Card to pay for qualified plan expenses. If you would also like to receive a Card for your spouse or dependent (age 18 years or older) you may do so by logging into your account at www.takecareWageWorks.com.

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 1 ***Commuter Parking Account***

YES ☐ I elect to contribute $ _____ per pay period to fund my account that pays qualified parking 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 2 ***Commuter Transit Account***

YES ☐ I elect to contribute $ _____ per pay period to fund my account that pays qualified commuting 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.

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 (selected above) set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election as set forth in my employer's plan. I acknowledge that I have received, read and understand the Summary Plan Description. I understand that the take care 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 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, and I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

Employee signature _____ Date _____

Return completed form to your employer.