ENROLLMENT FORM for the take care® FLEX BENEFITS PLAN

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/Mobile _____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 1 HEALTHCARE 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 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.

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 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 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 take care 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).

Employee signature_____ Date _____

Return completed form to your employer

*Effective for plan years beginning on or after January 1, 2013 participant salary reductions to your Healthcare FSA may not exceed the IRS indexed limit for the year. Consult your plan administrator for the current year limit.

(over for account description)

3240A (11/2014)

CONTRIBUTION MAXIMUMS FOR EACH BENEFIT ARE BASED ON A PLAN YEAR

OPTION 1—HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

The IRS sets the annual maximum contribution amount for the FSA. Check with your employer or review your Summary Plan Description (SPD) for contribution limits to the FSA.* The SPD is provided to you by your employer.

OPTION 2—DEPENDENT CARE / ELDER 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 before and after adult or child, elder day care through age 12, day care for a disabled adult or child, elder day care for parent or dependent, day camp thru age 12.

The IRS sets the annual maximum contribution the Dependent Care/Elder Care Account. See mytakecareplan.com for current year maximums.

OPTION 3—PRE-TAX PREMIUM ACCOUNT

This allows you to pay for your portion of your employer-sponsored insurance premiums on a pre-tax basis. Eligible expenses include health, dental, and vision.

Other insurance premiums may qualify. Check with your employer or review your Summary Plan Description (SPD).

take care®

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*Your participant salary reductions to your Healthcare FSA may not exceed the IRS indexed limit for the year. Consult your plan administrator for the current year limit. Salary reductions (contributions) to your Healthcare FSA limit may be less, review your Summary Plan Description (SPD) for contribution levels.

(over for enrollment form)