take care®
by WageWorks

Salary Redirection Agreement (SRA)

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 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Order an extra flex debit card for your spouse or dependent - 18 years or older. (Your card will be ordered automatically.)

Name of spouse or dependent (First, Last) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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 Health Care Account

☐ **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 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.

OPTION 4 Additional Benefit

(please insert description provided by your HR Department, if applicable) _____

☐ **YES** I elect to contribute $ ☐☐,☐☐☐ (before taxes) for the PLAN YEAR, which is $ ☐,☐☐☐.☐☐ per pay period for funding reimbursement of this additional benefit outlined by my Human Resources Department.

☐ **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).

USE OF PERSONAL INFORMATION – In addition to and without limiting in any way the rights my employer, the Plan, their service provider and their respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status and health and dependent child care information) as is reasonably required to administer the Plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer, the Plan, their service provider and their respective agents, employees, subcontractors and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of Plan administration or to detect or prevent fraud or misrepresentation.

Employee signature _____ Date _____

www.wageworks4me.com/takecare

WageWorks is a preferred vendor for the administration of Aflac's Cafeteria Plans (Health FSA and Dependent Day Care), Commuter Spending Accounts, and Health Savings Account (HSA) products and services. WageWorks is a separate entity from Aflac, and WageWorks will guarantee and warrant any products and services they offer based upon their own service policies.

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