take care® Flex 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.

OPTION 1A ***Health Care Account*** (check one) ☐ Flexible Spending Account (FSA) or ☐ Health Savings Account (HSA)

If you elect the HSA you must also complete the Health Savings Account Application and Eligibility Form if you do not currently have an HSA account with HSA Bank.

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 for a total pay period contribution of $ _____.

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*** Available only if you elect the "HSA" option above. The LFSA is in addition to the HSA. It is limited because you can only pay dental and vision expenses from this 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 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, daycare 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 daycare 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 HR 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). I understand that either my employer or its contracted service provider, as applicable, may request that I complete an account application to authorize the establishment of a bank account to enable Flex Benefits Card to access funds necessary for the payment of qualifying expenses, and the payment of qualifying expenses cannot be made without the establishment of such an account. I authorize my employer or its contracted service provider to establish an account for such purpose, and for my employer to authorize the transfer of applicable funds from my payroll to appropriately fund the account in accordance with my previous election(s), and/or to deduct the amount of qualified expenses from the account in settlement of Flex Benefit Card transactions. I further authorize the contracted service provider to have access to my account to complete the settlement of all qualifying trades and transactions, and to have access for customer service purposes to assist in resolving any outstanding claim issues or disputes that should arise on my behalf.

Employee signature _____ Date _____

Return completed form to your employer.

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