## FLEX DEBIT CARD OPTION

# ENROLLMENT FORM for the FLEX BENEFITS PLAN

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

Employer _____ Employee ID # _____

Employee Name *(First, Last)* _____

Social Security Number _____-_____-_____ Date of Birth (MM-DD-YYYY) _____-_____-_____

Mailing Address _____ Apt._____

City _____ State _____ Zip _____

Phone Number _____-_____-_____ E-mail _____

**Employer to complete or enrollment cannot be processed.** Plan year start (mm/dd/yy) ___/___/___ and end ___/___/___
First payroll start date___/___/___. No. of Pays_____.

## OPTION 1 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 healthcare expenses that are not covered by my employer's health plan or any other health plan. **Maximum contribution – $2700.00 per year**. (IRS may increase/decrease this amount periodically.)

❑ 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 Day Care Account

This pays for daycare 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 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 day care or elder care expenses. **Maximum contribution $5000.00.**

❑ 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.

YOU MAY ENROLL IN THE FOLLOWING BENEFITS ONLY IF THEY ARE OFFERED BY YOUR EMPLOYER. Check your Summary Plan Description or ask your employer.

## 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.

| | Salary Reduction Amount Per Pay Period | No. of Reductions Per Year |
|---|---|---|
| Group Medical ..... | | |
| Dental Coverage ..... | | |
| Short Term Disability ..... | | |
| Cancer ..... | | |
| Vision ..... | | |
| Accident ..... | | |
| Other ..... | | |

## OPTION 4 Debit Card

❑ YES – I would like the use of a debit card for my account. There is an annual charge of $**$12.00** for participant's card only.

The fee will be deducted from your Flex Account.

Spouse or Dependent's full name for 2nd take care flex benefits card *(First, Last)* _____

❑ NO – I decline the use of a debit card for my account.

**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 (Options 1 through 2) 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 understand that the take care debit 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 debit 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).**

**IMPORTANT: Cosmetic and elective procedures are not eligible for reimbursement. Please note, vitamins and supplements require a letter of medical necessity from your doctor. To view account balance, claims information, and "what's covered" – visit www.myflexonline.com.**

Employee signature _____ Date _____

White – Custom Benefit Services Yellow – Employer Pink – Employee

Fax (352)-369-9461