take care® Flex Benefits Plan

Enrollment Form

PLEASE PRINT. All information is required or your enrollment	t 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 fo Card for your spouse or dependent (age 18 years or older) you may do so by logg	
Employer to complete or enrollment cannot be processed.	
Plan year start (MM/DD/YY) <u>01/01/2020</u> and end <u>12/31/</u> 20	20 First payroll start date 01_/ 03/ 2020
No. of Pays <u>20</u> . Dept. <u>payroll</u> .	
YES ☐ I elect to contribute \$ (before taxes) for the PLAN Y qualified out-of-pocket healthcare expenses that are not covere NO ☐ I decline this option for this plan year and understand that I wi OPTION 2 Dependent Care Account	
	hat you may work. Eligible services include: nursery school, nanny, before d, elder day care for parent or dependent, day camp through age 12.
YES I elect to contribute \$ (before taxes) for the Plan Y	ear, which is \$ per pay period to fund my account that pays
qualified dependent daycare or elder care expenses. NO \Box I decline this option for this plan year and understand that I wi	l lose all tax savings that I could receive as a participant.
Employee signature	Date

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). © 2014 WageWorks, Inc. All rights rserved. 3593(09/2014)