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) _____

Home (Street) Address_____ Apt/Suite _____

City _____ State _____ Zip_____ Phone: _____

Email address: _____

Employer to complete. Plan year date (mm/dd/yy) ___/___/_____ and end ___/___/_____. Effective Date ___/___/_____. First payroll start date ___/___/_____. No. of Pay Periods _____

OPTION 1A | **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 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 1B | **LIMITED FLEXIBLE SPENDING ACCOUNT (LFSA)** **Available *only* if you have an HSA**. The LFSA is in addition to the HSA. It's 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 pay ONLY qualified dental and vision 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 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 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.

☐ **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 | **COMMUTER TRANSIT ACCOUNT**

☐ **YES** I elect to contribute $_____ (before taxes) for the PLAN YEAR, which is $_____ per pay period to fund my account that pays qualified commuting 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 4 | **COMMUTER PARKING ACCOUNT**

☐ **YES** I elect to contribute $_____ (before taxes) for the PLAN YEAR, which is $_____ per pay period to fund my account that pays qualified parking 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.

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 that year by an equal portion of the benefit elections (selected above) 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 flex benefits 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 paid with the card from any other source. I understand that when using the flex benefits 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

CONTRIBUTION MAXIMUMS FOR EACH BENEFIT ARE BASED ON A PLAN YEAR

OPTION 1A – HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

Your employer 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 1B – LIMITED FLEXIBLE SPENDING ACCOUNT (LFSA)

Available only if you elect to enroll in an HSA (Health Savings Account). The LFSA is an addition to the HSA account and is limited to paying only qualified dental and/or vision expenses that are not covered by your employer's health plan or any other health plan. Your employer sets the annual maximum contribution amount for the LFSA. Check with your employer or review your Summary Plan Description (SPD) for contribution limits to the LFSA.

OPTION 2 – DEPENDENT DAY CARE / ELDER CARE ACCOUNT

This pays for day care expenses for dependent child, adult or elder, so that you may work. Eligible services include: Nursery school, nanny and/or before/after school care thru age 12, day care for a disabled adult or child, elder care for parent or dependent, day camp thru age 12. The IRS sets the annual maximum contribution amount for the Dependent Day Care/Elder Care Account. Please visit www.cpnflex.com for current year maximums. (Please note: the take care® debit card is not linked to this benefit option).

OPTION 3 – COMMUTER ACCOUNT

The IRS sets the annual maximum contribution amount for the Commuter Account. Please visit www.cpnflex.com for current year maximums.

OPTION 4 – PARKING ACCOUNT

The IRS sets the annual maximum contribution amount for the Commuter Account. Please visit www.cpnflex.com for current year maximums.

take care®

www.cpnflex.com

CORPORATE PLANNING NETWORK

CPN