ENROLLMENT FORM FOR THE CPNFLEX 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 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 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 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.

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, and 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