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 _____

Employer to complete or enrollment cannot be processed.

Plan year start (MM/DD/YY) ____ /____ /____ and end ____ /____ /____. First payroll start date ____ /____ /____.

No. of Pays _____. Dept. _____.

## OPTION 1 *Health Care 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, before and after school care through age 12, day care for a disabled adult or child, elder day care 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.

Employee signature _____ Date _____

*Return completed form to your employer.*

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