## 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)	<u>                                     </u>	
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/		
	l understand that I will lose all tax savings that I could receive as a păi <sup>‡</sup>	
<b>DEPENDENT</b> 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 and/or before/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 \$(t	before taxes) for the PLAN YEAR, which is \$	per pay period to fund my
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		
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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 (selected above) set forth 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. I understand that qualified expenses paid with the Card or any other form of reimbursement cannot be reimbursed by any other plan and that I will not seek reimbursement from any other source. In addition, the expenses for which reimbursement is sought will not be claimed as tax deductions. 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 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	
(over for account description)	Return completed form to your employer 💢 🗡	

<sup>\*</sup> Your employer determines the maximum annual contribution limit for your plan, which cannot exceed \$2,500 effective 1/1/2013, per IRS rules. Confirm with your employer or check your summary plan description for the maximum annual contribution limit allowed for your plan.