take care® Flex Benefits Plan

Enrollment Form



PLEASE PRINT. All informa	tion is re	quired	or you	ur er	nrol	lment o	anno	be	prod	cesse	d.				1					
Employer						Social Security Number														
Employee Name (First, Last)																				
Date of Birth (MM-DD-YYYY)							Dat	e Hir	ed (N	им-DD)-YY	YY)						T		
Home (Street) Address																AP ⁻	т.	T		
City											St	ate			Z	ip [Ī	Ī		
Home Phone					En	nail			·					•	_	-				
By enrolling in the plan you will rec Card for your spouse or dependent	(age 18 year	rs or oldei	r) you m	nay do	d to	pay for qu											 ? a			
Employer to complete or enro Plan year start (MM/DD/YY)						,	1	Г:	not m	avrall.	o+ o +	ما م	t o		,		,			
No. of Pays										ayroll	star	rt da	ile _		. /		/			
YES ☐ I elect to contribute \$ qualified out-of-pock. NO ☐ I decline this option for the second sec	et healthca or this plan Care Acco ses for a dep a age 12, day daycare or or this plan o Save Ta enefit enrol share of the required of come will a or this plan	pendent cycare for (before elder car a year and epremius contribution year and a year and epremius contribution at year and epremius contribut	hild, ad a disab e taxes; e expe d under rm, I ha m for t ons for ally be	ult are rstan ult are rstan ult or old day of the second o	not d that a dult the F. d that e Pr nroll e empse in sted d that	covered er, so that or child, or Plan Year et I will lo emium led in cer ployee be surance to reflect at I will lo	t you melder day, which ose all of the second of the secon	employ wo say wo say wo say wo say wo say wo say car say will a say will a say will a say will a say wo say will a say wo	ver-sautor e.	s health us that ligible s parent us that ponsor natical reased us that	servi or d per I cou	nn or vild residence pay vild residence pay vild residence paidence paidence vild residence vild	any ecceiv ecceiv ance d with asec	de: n de: n de: n day od tc	r head a pad urse or cambo funda a pad efits e-tax	ry sc p thr d my rticil (i.e. c doll	hool rough acco	, nan h age ount Ith in I als	ny, b 12. that sura o	pays
YES ☐ I elect to contribute \$ this additional benefi NO ☐ I decline this option for	t outlined b	y my HR	depart	tmen	t.	Plan Year at I will lo													sem	ent of
IMPORTANT: Please read the following bequal portion of the benefit elections se changes in my status and that, prior to that I have received, read, and underst expenses paid with the Card cannot be that when using the take care® Card I mpayment is made that is not for qualified (if permitted by state law).	pefore signing t forth above the first day and the Sumi reimbursed b nust keep all	y this enroll and that qu of each pla mary Plan y any other receipts an	ment for alified e n year, I Descript plan an d that, o	rm. My expens will b tion. I d that	y emp es wi e offe unde I will asion	oloyer and Il be paid of ered the op rstand tha not seek r , I may be	l agree the agree to a second a distribution of the taken to a second a sec	nat my free ba ty to c ke care emen ir docu	rtaxak asis. I hange e® Car t for e ument	ole incon understa e my ben rd is ava xpenses ation of	ne wi and the nefit e silable s paid charg ze my	ll be r hat I r election to p with ges m r emp	reduce may cloon for ay on the C	ed ea hange the u ly qua ard fr with r	ch pay e my e ipcom alified rom ai	/ periodection per	od du on in t ilan ye enses ner so ilso ui	ring t he eve ear. I and t urce. nders	ent of ackno hat q I und tand	certair wledge Jualified erstand that if a
Employee signature											Da	ate_								