

# Enrollment for the take care Flex Benefits Plan

Employer code: CLK Social Security Number \_\_\_\_\_

Employee Name (First, Last) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Has this information changed since your last enrollment?  Yes  No

If this is the first time you have enrolled, we also need the following:

Date of Birth \_\_\_\_\_ Date of Hire (to be completed by employer) \_\_\_\_\_

By enrolling in the plan, you will receive a take care Card to pay for qualified expenses. If you would also like to receive a take care Card for your spouse or a dependent (must be 18 years old) please provide their name here (First Name, Last Name) \_\_\_\_\_

## 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 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.

## 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 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 \$ \_\_\_\_\_ (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 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. I understand that the take care Card 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 for expenses paid with the Card from any other source. 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 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 the completed form to 524 Westwood Road, Berryville, VA