

CONTRIBUTION MAXIMUMS FOR EACH BENEFIT ARE BASED ON A PLAN YEAR

OPTION 1A – HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Account (FSA) – Your employer sets the annual maximum contribution amount for the FSA. Check with your employer or review your Summary Plan Description (SPD) for contribution limits to the FSA. The SPD is provided to you by your employer.

OPTION 1B – LIMITED FLEXIBLE SPENDING ACCOUNT (LFSA)

Available only if you elect to enroll in an HSA (Health Savings Account). The LFSA is in addition to the HSA account and is limited to paying only qualified dental and/or vision expenses that are not covered by your employer's health plan or any other health plan.

Your employer sets the annual maximum contribution amount for the LFSA. Check with your employer or review your Summary Plan Description (SPD) for contribution limits to the LFSA.

OPTION 2 – DEPENDENT DAYCARE / ELDER 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 thru age 12, daycare for a disabled adult or child, elder daycare for parent or dependent, day camp thru age 12. The IRS sets the annual maximum contribution amounts for the Dependent Daycare/Elder Care Account. Maximum amount per calendar year is the lesser of: (1) \$5,000 for married filing joint or \$2,500 for married filing separate, (2) your spouse's total annual compensation or (3) half of your total annual compensation.

If you are single, the maximum amount is \$5,000. (Limits shown are 2009 limits).

OPTION 3 – ADOPTION EXPENSE REIMBURSEMENT ACCOUNT

Plan reimbursement rules differ for International vs. Domestic adoptions.

The IRS sets the annual maximum contribution amount for the Adoption Expense Reimbursement Account. Maximum amount per adoption attempt is \$12,150 (2009 limit). If additional expenses are incurred for the adoption of the child, a credit on your Form 1040 may also be available to you. Please consult your tax advisor for further details.

OPTION 3 – PRE-TAX PREMIUM ACCOUNT

This allows you to pay for your portion of your employer-sponsored insurance premiums on a pre-tax basis. Eligible expenses include health, dental, and vision.

Other insurance premiums may qualify.

Check with your employer or review your Summary Plan Description (SPD).

ADDITIONAL BENEFIT

Available only if offered by your employer. Description to be provided by your HR Department.

take care®

mytakecareplan.com

(over for enrollment form)



ENROLLMENT FORM FOR THE take care® FLEX BENEFITS PLAN

PLEASE PRINT. All information is required or your enrollment cannot be processed.

Employer _____ Employee Name (First, Last) _____

Social Security Number _____ Date of Birth (MM-DD-YYYY) _____ Date Hired (MM-DD-YYYY) _____

Home (Street) Address _____ APT. _____

City _____ State _____ Zip _____

Home Phone _____ - _____ - _____ E-mail _____

Employer to complete or enrollment cannot be processed. Plan year start (mm/dd/yy) ____/____/____ and end ____/____/____. First payroll start date ____/____/____. No. of Pays ____.

OPTION 1A 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 1B LIMITED FLEXIBLE SPENDING ACCOUNT Available only if you have an HSA. The LFSA is in addition to the HSA. It's limited because you can only pay dental and vision expenses from this account.

- YES I elect to contribute \$ _____ (before taxes) for the PLAN YEAR, which is \$ _____ per pay period to fund my account that pays only qualified dental and vision 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 a 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.

OPTION 3 ADOPTION EXPENSE REIMBURSEMENT ACCOUNT Plan reimbursement rules differ for International vs. Domestic adoptions.

- YES I elect to contribute \$ _____ (before taxes) for the PLAN YEAR, which is \$ _____ per pay period to fund my account that pays qualified adoption 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 4 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.

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 Human Resources 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 (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 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 law).

Employee signature _____ Date _____

(over for account descriptions)

RETURN COMPLETED FORM TO YOUR EMPLOYER