

FLEXIBLE SPENDING ACCOUNT ENROLLMENT APPLICATION

PLAN YEAR _____ THROUGH _____

Company Name _____

Employee Last Name _____ First Name _____

Social Security Number _____ Date of Hire _____

Address _____ City _____

State _____ Zip _____ Work Phone (____) _____

E-mail Address _____

Option I: Medical Reimbursement Account (Health FSA)

Enter **annual** pre-tax contribution amount up to your company's maximum election*: \$ _____

Option II: Dependent Care Reimbursement Account (DCAP)

Enter **annual** pre-tax contribution amount up to the maximum election of **\$5,000**: \$ _____
(Maximum for those married filing separate tax returns is \$2,500)

Option III: Mass Transit & Parking Reimbursement Plan

Enter **monthly** pre-tax TRANSIT amount up to the monthly maximum limit of **\$230.00** \$ _____
If available through your company, enter your **monthly** post-tax TRANSIT amount: \$ _____

Enter **monthly** pre-tax PARKING amount up to the monthly maximum limit of **\$230.00** \$ _____
If available through your company, enter your **monthly** post-tax PARKING amount: \$ _____

Option IV: Waiver of Tax Benefits:

- I have been given the opportunity to enroll in these tax-savings plans and have declined to participate. I understand that I will lose all tax savings that I may have received as a participant.

* See your company's Human Resources Department for maximum election information.

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in status. 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. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge that I have received, read and understand the Summary Plan Description.

Employee Signature _____ Date _____

For Employer Use Only

Eff Date: _____

DEPENDENT INFORMATION (COMPLETE THIS SECTION FOR DEBIT CARD ISSUANCE TO DEPENDENTS ONLY)

01 _____	Dependent Name	Relationship	SSN	DOB
02 _____	Dependent Name	Relationship	SSN	DOB
03 _____	Dependent Name	Relationship	SSN	DOB
04 _____	Dependent Name	Relationship	SSN	DOB
05 _____	Dependent Name	Relationship	SSN	DOB

DIRECT DEPOSIT AGREEMENT

Complete all information below. Attach a voided check directly to this section for the account you are authorizing for direct deposit – do not use a deposit slip. Your direct deposit cannot be processed without proper documentation.

Banking Institute Name: _____

ABA Routing Number: _____ (9 digit number located on the left side of your check)

Banking Account Number: _____

Checking _____ Savings _____

I hereby authorize BeneFlex, Inc. (hereinafter BeneFlex) to deposit any amounts (created by manual claims) owed me by initiating credit entries to my account at the financial institution (hereinafter **BANK**) indicated above. Further, I authorize BANK to accept and to post any entries initiated by BeneFlex to my account. In the event that BeneFlex deposits funds erroneously into my account at BANK, I authorize BeneFlex to debit said account. This authorization is to remain in full force and effect until BeneFlex and BANK have received written notice from me of its termination. I further understand that it is my full responsibility to inform BeneFlex within 5 business days via the submission of a DIRECT DEPOSIT AGREEMENT of any BANK and/or account changes. BeneFlex will charge my account at Bank \$6.00 for any items returned ACCOUNT CLOSED or NO ACCOUNT by the bank

Employee Signature _____ Date _____

BENEFLEX CONVENIENCE CARD – CARDHOLDER AGREEMENT

The Cardholder Agreement is available for viewing and printing at www.flexaccount.com under the BeneFlex Resource Center.

By signing below I certify that I have read the Cardholder Agreement and that I understand and agree with all of the terms and conditions outlined therein.

Employee Signature _____ Date _____