



Employer: _____ **Plan Year:** _____ **to** _____

Employee Name: First _____ MI _____ Last _____ Phone Number _____

Employee Street Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Social Security Number _____

E-mail address _____ Mother's Maiden Name (Security Purposes Only) _____

Print Name as it will appear on 1st Card (21 characters maximum) _____ Print Name as it will appear on 2nd Card (optional) (21 characters max) _____

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the plan effective date shown above & are not revocable during this time period unless I have a change in Family Status. I further authorize future adjustments in the amount of my salary reduction if the carrier changes the cost of coverage in any program selected below during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code and the Company's Summary Plan Description as provided to me.

<p><u>Premium Pass:</u></p> <p>Health: \$ _____</p> <p>Dental: \$ _____</p> <p>Vision: \$ _____</p> <p>Life: \$ _____</p> <p>Cancer: \$ _____</p> <p>Disability: \$ _____</p> <p>Cash Option: \$ _____</p> <p>Pre-tax Premium Totals \$ _____</p>	<p><u>FLEXIBLE SPENDING ACCOUNTS:</u></p> <p>Number of Pay Periods for Deductions: 12 24 26 52</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Accounts:</th> <th style="text-align: center;">Employer Flex Dollars by pay period</th> <th style="text-align: center;">Employee Flex Dollars by pay period</th> <th style="text-align: center;">Total Annual Election</th> </tr> </thead> <tbody> <tr> <td>Unreimbursed Medical</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Dependent Care</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Private Medical Premium</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Administration Fee paid by</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>	Accounts:	Employer Flex Dollars by pay period	Employee Flex Dollars by pay period	Total Annual Election	Unreimbursed Medical	_____	_____	_____	Dependent Care	_____	_____	_____	Private Medical Premium	_____	_____	_____	Administration Fee paid by	_____	_____	_____	<p><u>mySourceCard™ Enrollment Agreement</u></p> <p>As a participant in one or more of the Reimbursement Plans indicated on this form, you will be issued a mySourceCard™ MasterCard® Debit Card issued by Benefit Bank, and agree to use it according to the terms of this Agreement and the Cardholder Agreement that will be provided to you with the Card. You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank, or ATM. You understand that the Card is to be used <i>exclusively</i> for Qualified Expenses as defined by the Plan(s) in which you participate. If the Card is issued pursuant to a Reimbursement Plan as indicated on this form and you use the Card for an expense that is not a Qualified Expense, you are indebted to your flex account and must repay the full amount of the non-Qualified Expense. You agree to save all invoices and receipts related to any expense paid with the Card and upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-Qualified Expense and you will be required to remit payment to your plan. Payment may be in the form of an offsetting claim, personal check or ACH draft, or a deduction from your paycheck.</p>
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<p><u>FLEXIBLE SPENDING ACCOUNT PARTICIPANTS</u></p> <p><input type="checkbox"/> Please check here if your Employer offers the Flex debit card AND you wish to receive a debit card as a method of flexible spending reimbursement. (fees may apply)</p> <p>Please circle how you would like reimbursement: Electronic Transfer Check</p> <p>(If reimbursement by electronic transfer, please attach voided check) or indicate SAME or ON FILE</p>																						

DEBIT CARD ACCOUNT HOLDERS Please note: if you currently have a flex debit card—DON'T THROW IT AWAY OR REQUEST NEW CARD. It is good from year to year. **New cards have a one-time \$1.75 fee. Replacement cards have a \$5.00 replacement fee.**

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate**.
Signature _____ Date _____

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate**.
Signature _____ Date _____