FLEXIBLE BENEFITS PLAN ELECTION FORM & COMPENSATION REDIRECTION AGREEMENT

Company:

ALL FIELDS ARE REQUIRED – PLEASE PRINT

PLAN YEAR DATES: **To**

DIVISION: _____ **(if applicable) DOH** _____ **EFF DATE** _____

SOCIAL SECURITY NUMBER: _____

FULL NAME: _____

21 characters maximum including spaces if embossed on the WEX Health® Benefits Card

HOME ADDRESS: Street _____

City _____ **State** _____ **Zip Code** _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ **HOME PHONE:** _____

ELECTION OF BENEFITS

In accordance with my rights under the Plan, I elect the following amounts for each benefit I have selected. The Employer and I agree that my cash compensation will be redirected by the amounts set forth below for the Plan Year designated above.

I receive my paychecks:

☐ **Weekly**(52) ☐ **Biweekly**(26) ☐ **Biweekly**(24) ☐ **Semimonthly**(24) ☐ **Monthly**(12)

FLEXIBLE SPENDING ACCOUNT OPTIONS	PAY PERIOD ELECTION AMOUNT (Plan Year Amt ÷ # Pay Periods)	PLAN YEAR ELECTION AMOUNT (Pay Period Amt x # Pay Periods)
1. Limited Purpose Health Care Reimbursement Arrangement (if have HSA) *(maximum $ 3,050.00 per plan year)* **Only reimburses dental and vision expenses**	$ _____	$ _____
2. Dependent/Child Care Reimbursement Account *(maximum $ 5,000.00 per tax year)*	$ _____	$ _____

After completing your election above, **read the back of this form carefully**. Please **sign and date** the reverse side of this form **if you want to participate** in any of the **spending arrangement options above.**

EMPLOYER USE ONLY – PLEASE COMPLETE BEFORE SENDING COPY TO ADMIN AMERICA

FIRST DEDUCTION/PAY DATE: _____ **TOTAL NUMBER OF DEDUCTIONS:** _____

LIMITED PURPOSE HEALTH CARE REIMBURSEMENT

I understand that:

- Reimbursement will be available for "**qualifying health care expenses**" as described in the **Summary Plan Description.**
- **I cannot change or revoke my Medical Care Reimbursement Account at any time during the plan year unless I experience a "change in status" event.** Such change in status events are described in the **Summary Plan Description**.

DEPENDENT CARE REIMBURSEMENT

I understand that:

- Reimbursement will be available for "**qualifying dependent care expenses**" as described in the **Summary Plan Description**.
- **I cannot change or revoke my Dependent Care Reimbursement Account at any time during the plan year unless I experience a "change in status" event.** Such change in status events are described in the **Summary Plan Description**.

OTHER IMPORTANT TERMS AND CONDITIONS

I understand that:

- Before the first day of each plan year I will be offered the opportunity to make my benefit election for the new year**. If I do NOT complete and return a new election form prior to the first day of the new year**, I will be treated as having elected NOT to participate in reimbursement accounts effective for the new plan year.
- **I understand that my Employer has chosen to issue me a** *WEX Health*™ Visa® Benefits Card **for use with my flexible spending account, and I will receive a second card for my spouse or dependents.**. I also understand that I am required to submit appropriate proof of qualified expenses within 60 days of the date the expense is incurred.
- **I am solely responsible for notifying the Employer if I have reason to believe that an expense for which I have obtained reimbursement is not a qualifying expense. I understand that, upon notification, I must immediately re-pay my Employer for the amount of any non-qualified reimbursement and that my Card may be immediately suspended or revoked for failure to comply.**
- This agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before redirection hereunder, is at least equal to the amount of that redirection.
- The Plan Administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event he believes it is required in order to satisfy federal law.
- **Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later plan year. Plans that offer the rollover provision are subject to the aforementioned forfeiture for account balances over the rollover limit. See your plan documents for additional details. Plans that offer the grace extension allow dates of service after the plan year end up to the final grace date. See your plan documents for additional details.**
- My Social Security benefits may be slightly reduced as a result of my election.

Enrollment & WEX Health® Benefits Card Agreement

WEX Health® BENEFITS CARD AGREEMENT (applicable only if offered by your employer)

As a participant in one or more of your employer plans, you may be eligible to receive two WEX Health® Visa® Cards with your name on them. You agree to use them in accordance with this Agreement and the Cardholder Agreement that will be provided to you in the envelope with the two WEX Health® Visa® Cards.

You understand that the WEX Health® Visa® Card is restricted to certain merchant categories and is not accepted at all Visa® locations. You understand that you may not obtain a cash advance with the WEX Health™ Card at any merchant, bank or ATM. You understand that the WEX Health® Visa® Card is to be used ***exclusively*** for qualified expenses as defined by the plan(s) in which you participate. If the WEX Health™ Card is issued pursuant to employer plans and you use the card to pay for an expense that is not a qualified expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all receipts and invoices related to any expense paid using the WEX Health® Visa® Card. If required, you agree to submit copies of these documents attached to a signed claim form for review by Admin America, the Plan Service Provider. Failure to submit the receipt(s) when required will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

ENROLLMENT AGREEMENT

This agreement (1) is subject to the terms of the employer's Flexible Benefits Plan, Medical Care Reimbursement Plan and/or Dependent Care Assistance Plan in effect as amended from time to time, (2) shall be governed by and construed in accordance with applicable laws, (3) shall take effect as a sealed instrument under applicable laws, and (4) to the extent allowed by law, revokes any prior election and compensation redirection agreement relating to such plan(s) for the corresponding Plan Year.

Employee's Signature: _____ **Date:** _____