

EMPOWER Flex Plan Enrollment Form

Employees: Complete and return this form to your Human Resources representative

Employers: Collect the completed forms from employees and follow the instructions at <https://employer.empowerflex.com/enrolling-consumers/> to submit enrollment

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|---------------------------------|-------------------------------|
| Employer _____ | SSN _____ |
| Employee Name _____ | Hire Date ____/____/____ |
| Email _____ | |
| Employee ID _____ | Date of Birth ____/____/____ |
| Home Address _____ | Work Phone (____) ____-____ |
| City _____ State ____ Zip _____ | Mobile Phone (____) ____-____ |

Option I: Healthcare Spending Account

Standard FSA – *Only available if not enrolled in an HSA Account.*
I want to save on healthcare expenses that my health insurance plan does not cover (copayments, deductibles, costs for dental, orthodontic, vision care, pharmacy, etc.).

Limited FSA – *Most often paired with an HSA Account. Only Covers dental and vision expenses.*
I want to save taxes on dental/vision expenses my health insurance plan does not cover.

I elect to contribute \$ _____ (before taxes) per Plan Year, which is \$ _____ per pay period, to fund my medical reimbursement expense account.

I Decline to participate in Option I this Plan Year.

Option 2: Dependent Daycare Spending Account

I want to save taxes on daycare expenses. I understand that I may claim up to \$5,000 if I am single or married filing jointly, or \$2,500 if I am married filing separately.

I elect to contribute \$ _____ (before taxes) per Plan Year, which is \$ _____ per pay period, to fund my dependent care account.

I Decline to participate in Option II this Plan Year.

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 only change my election if I have a qualifying event as determined by the IRS. 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. Depending on the specifics of my Employer's Plan, any contributions 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 ____/____/____