HEALTH CHOICES
your self-funded solution

PARTICIPATION FORM FOR THE MYFLEX FLEXIBLE BENEFITS PLAN

Employer ______________________ Employee Name ______________________

Social Security# ______________________ Date of Birth ______________________

Home Address ______________________ City __________ State ______ Zip ________

Home Phone (____) ______________________ E-mail ______________________

To be completed by employer

Employee# ______________ Plan year start (mm/dd/yy) ____/____/____ and end ____/____/____

Dept ______________ First payroll start date ____/____/____ Pay Cycle ______________

OPTION 1 Healthcare Flexible Spending Account Agreement

☐ 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 healthcare expenses not covered by my health and other insurance plans.

☐ 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 Benefit Account

☐ YES I elect to contribute $__________ (before taxes) for the PLAN YEAR, which is $ __________ per pay period to fund my account that pays qualified dependent care expenses. 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.

☐ 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 Employer Benefit Plan Premiums

☐ 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.

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 (1 and 2) 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 have also read and understand the Important Information included in this booklet.

I understand that the flexible spending debit card is available to pay only qualified expenses. I understand that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expense not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

Employee Signature ______________________ Date ______________