AMERIFLEX®

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

Company Name: _____

Employee Name: _____ Telephone: _____

Employee Address: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Employee Social Security Number: _____ Plan Year: _____ through _____

Date of Birth: _____ Date of Hire: _____ Effective Date: _____

The Company and I hereby agree that my cash compensation will be redirected by the amounts set forth below for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement). I understand that if I do not return this form to my employer by my effective date, it shall constitute my election to waive participation in all flexible spending programs under my employer's Flexible Benefits Plan and therefore cause me to pay non-reimbursable medical, dependent care, and/or commuter expenses (if any) with after-tax dollars.

EMPLOYEE'S FLEXIBLE BENEFIT PER PAY DEDUCTION/ALLOCATION

Medical Flexible Spending Account

Per pay contribution $ _____ Date of first payroll _____

$ _____ Maximum ANNUAL Contribution Annual contribution $ _____ Number of remaining pays _____

☐ Check here if the above Medical FSA election should be Limited Purpose (i.e. Vision & Dental Only)

Dependent Care Spending Account

Per pay contribution $ _____ Date of first payroll _____

$ _____ Maximum ANNUAL Contribution Annual contribution $ _____ Number of remaining pays _____

Commuter Reimbursement Account

PARKING

Per pay contribution $ _____ Date of first payroll _____

$ _____ Maximum MONTHLY Contribution Annual contribution $ _____ Number of remaining pays _____

TRANSIT

Per pay contribution $ _____ Date of first payroll _____

$ _____ Maximum MONTHLY Contribution Annual contribution $ _____ Number of remaining pays _____

I UNDERSTAND THAT:

(1) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.

(2) I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, or such other events as the Plan Administrator determines will permit a change or revocation of an election).

(3) The Plan Administrator may reduce, cancel, or otherwise modify this agreement in the event he/she believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).

By signing this form I agree to the terms and procedures listed herein.

☐ I was given the opportunity to participate in this Flexible Benefits Plan, and I have decided not to participate at this time.

_____

Employee Signature Date

AMERIFLEX 302 FELLOWSHIP ROAD, SUITE 100, MOUNT LAUREL, NJ 08054 WWW.FLEX125.COM
CALL TOLL-FREE: 888.868.FLEX (3539) **FAX:** 800.282.9818

AMERIFLEX® **FSA ENROLLMENT**/continued

ADDITIONAL CARDS (only applicable if your employer has chosen this option)

If you wish to have an AmeriFlex Convenience Card® issued for a spouse or dependent, please be sure your spouse or dependent meets the IRS eligibility guidelines below:

(1) For federal tax purposes, a *spouse* is defined as ". . . a person of the opposite sex who is a husband or wife." Same sex domestic partners are not considered spouses for purposes of FSA administration. A person residing in the employee's home, who the employee provides over half of their support, who is not the employee's spouse under applicable state law, and who is not a family member, is considered a dependent under Internal Revenue Code 152(a) without regard to 152(b)(1), (b)(2), and (d)(1)(B).

(2) For purposes of Medical FSAs, *dependent* includes any relative of the participant for whom the participant provides over half of their support for the calendar year. A relative includes children, parents, stepchildren, siblings, aunts, uncles, cousins, and in-laws of the participant. Relatives do not need to reside with the participant in order to be dependents, nor do they need to be a certain age or infirmity; they need only to be persons for whom the participant has provided over half of their support.

Spouse Name: _____

Address to issue card: _____

Telephone: _____ Soc. Sec. Number: _____ Date of Birth: _____

All dependents must be age 18 or over in order to receive the AmeriFlex Convenience Card®.

Dependent Name: _____

Address to issue card: _____
(if different from participant)

Telephone: _____ Soc. Sec. Number: _____ Date of Birth: _____

Dependent Name: _____

Address to issue card: _____
(if different from participant)

Telephone: _____ Soc. Sec. Number: _____ Date of Birth: _____

Each AmeriFlex Convenience Card® is issued for a term of three years. Remember that existing cardholders will not receive a new card (unless the current card is scheduled to expire). Cards will simply be "reloaded" for the next plan year with your new election. Upon expiration, AmeriFlex will automatically issue new cards to participants who re-enroll in the new plan year. For new participants, your AmeriFlex Convenience Card® will be sent to your home adress in a plain white envelope.

AUTHORIZATION AGREEMENT FOR ACH DEBITS/CREDITS

I, hereby, authorize AmeriFlex, LLC, hereafter called ADMINISTRATOR, to initiate debits and/or credits to or from my bank account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit and credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge the origination of ACH transactions to or from my account must comply with the provisions of U.S. law.

Depository Name: _____ Account Name: _____

City: _____ State: _____ Zip: _____

Routing Number: _____ Account Number: _____
(always nine digits)

SELECT ONE: ☐ Checking Account ☐ Savings Account

If you would prefer, please attach a voided check.

The authorization is to remain in full force and effect until the ADMINISTRATOR has received written notification from the employee named above of the termination in such time and in such manner as to afford the ADMINISTRATOR and DEPOSITORY a reasonable opportunity to act on it.

Date: _____ Signature: _____

Upon receipt, the Federal Reserve requires 14 business days to perform the initial approval of the ACH information. After this time, AmeriFlex will be directly depositing all claim reimbursements into the bank account provided two days after every processing date determined by your employer.

It may take up to 5 business days to have your reimbursements appear in your account, depending upon the automated clearing house utilized by your bank. We suggest that you contact your bank to confirm when these funds become available in your account. AmeriFlex shall not be responsible for any checks or other debt payments you make whereby you have assumed these funds are available.

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