ENROLLMENT FORM FOR THE Eagles Benefits FSA BENEFITS PLAN

PLEASE PRINT. All information is required or your enrollment cannot be processed.

Employer _____ Social Security Number

Employee Name *(First, Last)*

Date of Birth (MM-DD-YYYY) Date Hired (MM-DD-YYYY)

Home (Street) Address APT.

City State Zip

Home Phone Email

Employer to complete or enrollment cannot be processed. Plan year start (MM/DD/YY) _____ /_____ /_____ and end _____ /_____ /_____.
First payroll start date _____ /_____ /_____. No. of Pays _____. Dept. _____.

OPTION 1A HEALTHCARE ACCOUNT—FLEXIBLE SPENDING ACCOUNT (FSA)

☐ 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 that are not covered by my employer's health plan or any other health plan.

☐ 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 1B LIMITED FLEXIBLE SPENDING ACCOUNT (LFSA)

Available *only* if you have a Health Savings Account (HSA). The LFSA is in addition to the HSA. It's limited because you can only pay dental and vision expenses from this account.

☐ 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 that are not covered by my employer's health plan or any other health plan.

☐ 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 ACCOUNT

This pays for day care expenses for a dependent child, adult, or elder, so that you may work. Eligible services include: nursery school, nanny and/or before/after school care through age 12, day care for a disabled adult or child, elder day care for parent or dependent, day camp through age 12.

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

☐ 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 AGREEMENT TO SAVE TAXES ON INSURANCE PREMIUMS

☐ YES On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance). I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

☐ 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.

IMPORTANT – Please read the following before signing this enrollment form. 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 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 understand that the take care® Card is available to pay only qualified expenses and 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 understand that when using the take care Card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my Card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

Employee signature _____ Date _____

Return completed form to your employer