

Enroller Code No. _____



Flexible Compensation Enrollment Form

Make sure to sign and date the enrollment form. Every line must be completed. Please enter zero (0) where no amount is being deducted. Return the completed and signed form to your employer. For enrollment assistance call 1-800-422-4661. Have your enrollment form, Client ID, and company name ready. You may also enroll on-line at www.accesstasc.com.

Client ID _____ Employer Name _____ Social Security Number _____

Employee Last Name _____ First Name _____ Middle Initial _____

Employee Address _____ City _____ State _____ Zip _____

Number of pay periods _____

| | Plan Year Election Amount |
|-----------------------------------------------------------------------------------------|------------------------------|
| 1. Medical Expenses (EEXP) (Out-of-pocket medical expenses) | \$ _____ |
| 2. Dependent Day Care (DEPC) (Not to exceed \$5,000 in a calendar year) | \$ _____ |
| 3. Non-Employer Sponsored Premiums (106P) (Independently-purchased insurance) | \$ _____ |
| 4. Transportation Expenses (TRAN) | \$ _____ |
| 5. Health Savings Account (FHSA) | \$ _____ |

If elections are not evenly divisible by the number of pay periods, the amount will be rounded down (i.e. \$500 election divided by 12 pay periods equals \$41.66 per pay period, for a total deduction of \$499.92).

If electing the HSA complete the following - Send my HSA contribution to:

- My financial institution (Complete the HSA Financial Institution Form)
- TASC default financial institution HSA Bank

By indicating an annual benefit amount for an HSA contribution, you are verifying that you are eligible to participate in a Health Savings Account (based on the rules established by the IRS) and that you have or will open a qualified Health Savings Account.

AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire Plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my payroll department.

Signature _____ Date _____

Enrollment Form Instructions

Client ID and Employer Name: Enter your Client ID and Employer name in the space indicated. Refer to your employer for the correct Client number and Employer name. Make sure to have this information available when calling for enrollment assistance. Check whether this enrollment is for a new (first-time) enrollment or for the renewal of a previous flexible spending account. If this is a mid-year election, calculate only the number of payroll deductions remaining in the year.

1. Medical Expenses: This amount is usually paid per year toward deductible and co-insurance portions of health insurance, dental expenses, orthodontic expenses, eye care and other miscellaneous health care expenses. After determining the payroll amount, multiply that number by the number of payrolls to determine your annual election. Check with your employer for the amount you may deduct.

2. Dependent Day Care: Amount paid for day care expenses per year. The maximum allowable amount under IRS regulations is \$5,000 per calendar year per family. This limit holds fast regardless of the number of dependents you may have.

3. Non-Employer Sponsored Premium: Privately purchased insurance premiums, including health, disability, cancer and term life insurance. Group insurance premiums deducted from your paycheck for your employer-sponsored plans **DO NOT** qualify within this category. Insurance premiums deducted through your spouse's employer are not eligible. Term life insurance premiums for the employee only can be deducted up to the first \$50,000 (in death benefits), including any term life insurance elected through your employer sponsored premiums to determine limits.

4. Transportation Expenses: Amount paid for costs per year associated with a commuter highway vehicle to travel to and from work. Includes costs associated with transit passes as well as qualified parking. Not to exceed \$100.00 per month for highway vehicle or transit passes, or \$195.00 per month for qualified parking.

5. Health Savings Account: Amount paid for certain out-of-pocket qualified medical expenses. The funds are deposited into a selected financial institution custodial account. When the qualified expense is incurred a reimbursement request for the custodial account is made to pay for the expense. The contribution amount is the lesser of either (1) the amount of the deductible under the High Deductible Health Plan or (2) \$2,650 under single coverage, or \$5,250 under family coverage.

Signature and Date: Make sure to sign and date the enrollment form. Return the completed and signed form to your employer.