Forward form to Lois Vega Fax (410) 674-2305 Email: lois_vega@us.aflac.com

take care® Flex Benefits Plan

Enrollment Form NEW HIRE FORM

take care® by WageWorks

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

Employer Florida Conference of SDA 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

By enrolling in the plan you will receive a take care® Flex Benefits Card to pay for qualified plan expenses. If you would also like to receive a Card for your spouse or dependent (age 18 years or older) you may do so by logging into your account at www.takecareWageWorks.com.

Employer to complete or enrollment cannot be processed.

Plan year start (MM/DD/YY) 01 / 01 / 2017 and end 12 / 31 / 2017 **First payroll start date** ____ / ____ / ____.

No. of Pays _____. Dept. _____.

OPTION 1 *Healthcare 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, before and 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 daycare 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.

OPTION 4 *Additional Benefit* (please insert description provided by your HR department, if applicable)

_____

YES ☐ I elect to contribute $ _____ (before taxes) for the Plan Year, which is $ _____ per pay period for funding reimbursement of this additional benefit outlined by my HR department.

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.

Florida Conference of SDA

Flexible pending for New Hires

You are eligible to participate 30 days after your hire date. Your eligibility to participate as a New Hire will terminate 30 days after your eligibility date (i.e., hired 1 July, eligible 1 August, new hire eligibility terminates 30 August).

Your annual election should be based on the number of deductions you will have once you are enrolled (i.e., above employee's 1st deduction will be 9/27/17, which will give him 4 deductions for the remainder of the Plan Year).

The Max Annual Election Amounts are: **URM (Healthcare Account) $2600**
DDC (Dependent Daycare) $5000

You will be issued a TakeCare card from WageWorks. This works just like a debit card; you swipe the card just like a debit card to pay for your eligible out-of-pocket expenses. The card is reloadable for 3 years. Once you receive the initial card, you can request a card for your Spouse on the WageWorks website (below); only you can request an additional card.

There is a **90-day Run-off Period**. This means you have 90 days after the plan year ends to file your claims (March 30th – there are never any exceptions).

The account has a **$500 Rollover**. For URM, funds up to $500 not spent will be automatically rolled over to the next plan year. This $500 can be added to any new election you might make for the new Plan Year. The Rollover amount remains in your account until you spend it. Your Annual Election DOES NOT roll over. If you DO NOT complete a new Enrollment Form for the new Plan Year, your deductions will stop and you will not be enrolled (you will only have your rollover amount, if applicable). If you do not sign up for the new plan year and have a rollover, you will need to file a paper claim, as your Debit Card will be closed.

You cannot change or stop your deductions unless you have a Change in Status event that would allow you to make a change.

Once enrolled, you should log in to **www.takecarewageworks.com**, click on Employee, and set yourself up with a login and password to have access to your account on line. You will be able to see everything going on in your account. This is where you would request an additional card. Information regarding the Flexing Spending Plan can also be found on this site. Lots of good information.

If your card is Lost or Stolen, YOU must report it and request a new one at 866-679-7649.

There is a $4.00 participant fee. You need to sign the Payroll Deduction Authorization Form to have the fee deducted from your pay. Forward with the Enrollment Form to Lois Vega.

Aflac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name _____
Last First MI

SSN/Emp. ID _____

I hereby authorize my employer:
Florida Conference of SDA ,

employer Payroll Account No. ATA66 , to deduct from my earnings such amounts as may now or hereafter be payable by me under the insurance plan purchased through Aflac. In the event of a rate change, I authorize a corresponding change in the amount deducted from my earnings.

In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a change in family status and permitted by my employer.

Signature of Applicant _____ Date _____

WAIVER OF PARTICIPATION

I certify that the features and benefits of Aflac's guaranteed-renewable insurance policies have been explained to me completely.

I understand that these policies are offered through my employer by payroll deduction.

- ☐ I am NOT currently an Aflac policyholder and have decided to waive my opportunity to participate at this time.
- ☐ I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time.

EMPLOYEE'S SIGNATURE _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction _____

Deduction Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly X Monthly

	OLD		NEW	
	AFTER-TAX	PRE-TAX	AFTER-TAX	PRE-TAX
☐ Other FSA Fee	$		$ 4.00	
☐ Cancer/Specified-Disease	$		$	
☐ Return of Premium Rider	$		$	
☐ Dental	$		$	
☐ Vision	$		$	
☐ Hospital Intensive Care	$		$	
☐ Specified Health Event	$		$	
☐ Hospital Confinement Indemnity	$		$	
☐ Accident	$		$	
☐ Disability Rider	$		$	
☐ Short-Term Disability	$		$	
☐ Life				
Employee	$		$	
Dependent	$		$	
TOTAL	$		$	

The amount of deduction and frequency thereof shall be determined by my employer and based on a plan that will comply with the payment checked above.

Insurance Agent/Producer	Date	Insurance Agent/Producer's Writing No.	Insurance Agent/Producer's Phone No.
Lois Vega		V0482	301-513-0381