PAYFLEX®

Reimbursement Accounts Enrollment Form

A. Personal Information (Be sure to print clearly and complete each section)

Employer Name **TW Ventures Inc. Flexible Spending Account Plan – Group #139064**		
Employee First Name	**Last Name**	**Social Security Number**
Street Address		
City	**State**	**Zip Code**
Employee email	**Date of Birth (MM/DD/YYY)**	

B. **Election Information** (Check the box to indicate if you wish to enroll)

☐ **Yes, I wish to participate in the Benefit Choice(s) offered below. I authorize payroll deductions on a pre-tax basis in the amount listed below. I know this election is for the entire Plan year.**

BENEFIT CHOICES	PLAN YEAR AMOUNT
Health Care Flexible Spending Account (HCA) • **Your employer's Plan sets the minimum and maximum contribution amounts, up to the Internal Revenue Service (IRS)**	**$**_____
Dependent Care Flexible Spending Account (DCA) • **Your employer's Plan sets the minimum contribution amount. The maximum contribution is $5,000, as set by the IRS.** • **If you're married and your spouse is disabled, a full-time student earns less than you or if you file separate tax returns, your contribution limit may be lower. Review your Plan for more information. You can also refer to IRS publication 503 at irs.gov.**	**$**_____

By signing this, you agree to the following statements:

- I know this election is for the entire Plan year.
- I know that the only way to change my election during the Plan year is if I have a change in status or become ineligible to participate. The new election must be consistent with my change in status. I must apply for it within 30 calendar days of the change or as allowed by the Plan, and my employer must approve it.
- My employer will change or cancel this election, if needed, to comply with the Internal Revenue Code.
- If I elect the DCA, I understand that the IRS sets the maximum salary contribution allowed. My tax filing status and if married, my spouse's income limits the amount. I know I must file IRS Form 2441 with my income tax return.
- I know that I will forfeit any amounts left in my account at the end of the Plan. This is defined in the Plan document.
- I know that funds can't be transferred between these accounts.
- I know that for HCA and/or DCA I need to complete and submit a new Enrollment Form for each Plan year. If I don't complete and return an Enrollment Form during Open Enrollment, I won't be able to participate in these accounts for that Plan year.
- If I elect the HCA and/or DCA, I understand that when I elect pre-tax salary deductions, Social Security and Medicare taxes are not withheld from those amounts.
- If I elect the HCA and/or DCA, I understand that I cannot claim the amount of salary deductions on my or my spouse's income tax returns.
- I know that if my employment ends, I can only claim medical expenses incurred through my period of coverage. This is defined in the Plan document.
- I know that I have to include documentation with each claim to show that the expense is eligible for reimbursement.
- If I use my PayFlex Debit Card, I agree to use the card for eligible expenses only and to keep all itemized receipts and statements. I agree to read and adhere to the cardholder statement I receive with the card. I know the card my be turned off if I don't comply with the card rules or if my employment ends and I no longer have this account.
- When I use my PayFlex Debit Card or submit a claim, I haven't been reimbursed and I won't seek reimbursement elsewhere.

C. **Pre-Authorization for Direct Deposit** (ignore if you are already enrolled or do not wish to participate).

☐ **I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursement.** This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement. **A "VOIDED CHECK OR SAVINGS DEPOSIT SLIP MUST ACCOMPANY DIRECT DEPOSIT APPLICATION**

Employee Signature _____ **Date** _____