SECURE BENEFITS SYSTEMS

Employer:_____Plan Year: _____to_____

Employee Name: First MI Last _____ **Daytime Phone Number** _____

Employee Street Address _____ **City** _____ **State** _____ **Zip Code** _____

Date of Birth (required) _____ **Social Security Number (required)** _____

E-mail address (required) _____

If your employer offers the debit card and you wish to sign up for a flex debit card, please check the box below. You will receive TWO (2) cards for your account – both will be in the participants name as it is the employee's account. Spouse/dependents may use your secondary card as you authorize. PLEASE CHECK BOX BELOW IF YOUR EMPLOYER OFFERS THE DEBIT CARD AND YOU WISH TO RECEIVE CARDS AS A FORM OF REIMBURSEMENT.

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the plan effective date shown above & are not revocable during this time period unless I have a change in Family Status. I further authorize future adjustments in the amount of my salary reduction if the carrier changes the cost of coverage in any program selected below during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code and the Company's Summary Plan Description as provided to me.

Premium Pass:

Health: $_____
Dental: $ _____
Vision: $ _____
Life: $ _____
Cancer: $ _____
Disability: $_____
Cash Option: $_____

Pre-tax Premium Totals $_____

These elections are evergreened and the pre-tax election carries over from year to year unless you make a change in writing.

FLEXIBLE SPENDING ACCOUNTS:

Number of Pay Periods for Deductions: 12 24 26 52

Accounts:	**Employer Flex Dollars by pay period**	**Employee Flex Dollars by pay period**	**Total Annual Election**
Unreimbursed Medical	_____	_____	_____
Dependent Care	_____	_____	_____
Private Premium (private major medical (healthcare) plans are no longer eligible)	_____	_____	_____
Administration Fee paid by	_____	_____	_____

Do you or your spouse participate in an HSA plan? YES NO
(if YES, you can only use Unreimbursed medical for dental & vision expense)

FLEXIBLE SPENDING ACCOUNT PARTICIPANTS

☐ Please check here if your Employer offers the Flex debit card ***AND*** you wish to receive a debit card as a method of flexible spending reimbursement. (fees may apply)

Please circle how you would like reimbursement: Electronic Transfer Check

(If reimbursement by electronic transfer, please attach voided check)

***Flexcard*™ Enrollment Agreement**

As a participant in one or more of the Reimbursement Plans indicated on this form, if requested, you will be issued a *WEX flex* Debit Card, and agree to use it according to the terms of this Agreement and the Cardholder Agreement that will be provided to you with the Card. You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank, or ATM. You understand that the Card is to be used ***exclusively*** for Qualified Expenses as defined by the Plan(s) in which you participate. If the Card is issued pursuant to a Reimbursement Plan as indicated on this form and you use the Card for an expense that is not a Qualified Expense, you are indebted to your flex account and must repay the full amount of the non-Qualified Expense. You agree to save all invoices and receipts related to any expense paid with the Card and you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-Qualified Expense and you will be required to remit payment to your plan. Cards will suspend if not provided timely. Payment may be in the form of an offsetting claim, personal check or ACH draft, or a deduction from your paycheck. Eligible claims for card payments dates of service MUST be in the current plan year .

DEBIT CARD ACCOUNT HOLDERS Please note: if you currently have a flex debit card–DON'T THROW IT AWAY OR REQUEST NEW CARD. It is good from year to year. **Replacement cards have a $10.00 replacement fee.**

To Authorize Participation: I hereby certify the above information to be correct and true and choose **to participate**.
Signature_____ Date_____

To Decline Participation: The benefits of the plan have been thoroughly explained to me, but I choose **not to participate**.
Signature_____ Date_____