take care® by WageWorks

Enrollment Form for the take care® Commuter 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

By enrolling in the plan you will receive a take care Card to pay for qualified plan expenses. If you would also like to receive a take care Card for your spouse or a dependent (must be 18 years old) please provide their name here. (First Name, Last Name)

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 Commuter Parking Account (before taxes)

☐ **YES** I elect to contribute $ ___ per pay period to fund my account that pays qualified parking 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 1B Commuter Parking Account (post taxes)

☐ **YES** I *also* elect to contribute $ ___ per pay period to fund my account that pays qualified parking 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 2A Commuter Transit Account (before taxes)

☐ **YES** I elect to contribute $ ___ per pay period to fund my account that pays qualified commuting 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 2B Commuter Transit Account (post taxes)

☐ **YES** I *also* elect to contribute $ ___ per pay period to fund my account that pays qualified commuting 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.

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 (selected above) set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election as set forth in my employer's plan. 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 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, and 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.