##11BENEFL##################

Clarity Benefits Solutions

FLEXIBLE SPENDING ACCOUNT ENROLLMENT APPLICATION

Plan Year January 1, 2017 through December 31, 2017

Employer _____

*Employee Last Name _____ *First Name _____

*Social Security Number _____ Date of Hire _____/_____/_____

*Address _____ *City _____

*State _____ *Zip _____ Phone (_____) _____

(Check here for mobile device)

*E-mail Address _____

* Required fields

Option I: Medical Reimbursement Account (Health FSA)

Enter **annual** pre-tax contribution amount up to your company's maximum election: **$2,600** **$**_____

Option II: Dependent Care Reimbursement Account (DCAP)

Enter **annual** pre-tax contribution amount up to the maximum election of **$5000** **$**_____

(Maximum for those married filing separate tax returns is $2500)

Option III: Transportation Reimbursement:

Enter **monthly** pre-tax TRANSIT amount up the monthly maximum of **$255** **$**_____

Enter **monthly post-tax** TRANSIT amount: **$**_____

Option IV: Parking Reimbursement:

Enter **monthly** pre-tax PARKING amount up the monthly maximum of **$255** **$**_____

Enter **monthly post-tax** PARKING amount: **$**_____

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in status. Prior to the first day of each plan year and in accordance with Plan guidelines, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. I acknowledge that I have received, read and understand the Summary Plan Description.

For Employer Use Only

Eff Date: ____/____/_____

*Employee Signature _____ Date_____/_____/_____

DEPENDENT INFORMATION (COMPLETE THIS SECTION FOR DEBIT CARD ISSUANCE TO DEPENDENTS ONLY)

Please provide us with Dependent information if you would like a Clarity Convenience Card (previously known as Beneflex) to be issued to the dependents listed below. Please note the dependent must be age 18 or older to receive a card.

	*Dependent Name	*Relationship	*SSN	*DOB
01	_____	_____	_____	_____
02	_____	_____	_____	_____
03	_____	_____	_____	_____

Clarity CONVENIENCE CARD – CARDHOLDER AGREEMENT

The Cardholder Agreement is available for viewing and printing at **https://claritybenefitsolutions.com/** under the Clarity Resource Center. By signing below I certify that I have read the Cardholder Agreement and that I understand and agree with all of the terms and conditions outlined therein.

Employee Signature_____ Date_____/_____/_____

Clarity 77 Brant Avenue, Suite 206, Clark, New Jersey 07066 Email: customerservice@claritybenefitsolutions.com
Telephone: 732-428-8282 Fax: 877-767-8821 Toll Free: 888-423-6359 Web: **https://claritybenefitsolutions.com/**