Plan Year _____ Employer Name _____

PIOPAC Fidelity

Salary Redirection Agreement

1. Participant Information

Employee Name _____ Social Security No. _____ Birthdate _____

Street Address _____ City _____ State _____ Zip Code _____ Contact Number _____

Email -(Required for WEX Health Card and account notifications) _____ Eligibility Date _____ Effective Date _____

2. Benefit Election

☐ Initial Enrollment ☐ Renewal ☐ Waive Participation

Medical FSA: $ _____ per pay period X _____ no. of deductions = $ _____ annual election

(Must not exceed your company maximum)

Dependent Care FSA: $ _____ per pay period X _____ no. of deductions = $ _____ annual election

($5,000 maximum annual election for single parent and married couple filing joint tax returns and $2,500 for married couple filing separate tax returns)

Transportation Benefit: $ _____ per pay period X _____ no. of deductions = $ _____ annual election

Parking Benefit: $ _____ per pay period X _____ no. of deductions = $ _____ annual election

***By signing this form I authorize my employer to deduct from my paycheck as shown above for my FSA elections.**

3. WEX Health Card

☐ I already have a WEX Health Card and will continue to use it

☐ I am a new participant and would like a WEX Health Card

☐ I am a current participant and would like a WEX Health Card

Two cards, both in your name will be ordered. Please note that these cards can be used by a dependent as long as he/she signs the back of the card.

* A $10.00 fee will be assessed to my FSA account for any replacement cards

4. Direct Deposit

Your Financial Institution _____ Routing Number _____

☐ Checking Account

☐ Savings Account

Financial Institution Address _____ Account Number _____

*Please attach a voided check to this authorization. *There is a re-processing fee of $15.00 if the deposit is returned (for any reason) or due to closed account or incorrect information entered/submitted.

I authorize PIOPAC Fidelity to initiate credit entries and, if errors occur, I authorize correcting entries to my account indicated below.

Employee Signature: _____ Date _____

5. Employee Signature

On or after the first fay of the plan year I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a "change in status" occurs (as defined under the plan and IRS). All claims reimbursed through the WEX Health Card are subject to IRS substantiation requirements and I am required to, and agree to, provide documentation as requested. If using the WEX Health card, I agree to use the card for eligible expenses only. I understand additional fees may be charged for non-qualified expenses or for unsubstantiated claims.

Employee Signature: _____ Date _____