

## Salary Redirection Agreement (SRA)

PLEASE PRINT. All information is required or your enrollment cannot be processed.	
Employer T-L Irrigation Co. Social Security Number	
Employee Name (First, Last)	
Date of Birth (MM-DD-YYYY)	
Home (Street) Address APT.	
City State Zip	]
Home Phone Email	
Order an extra flex debit card for your spouse or dependent 18 years or older. (Your card will be ordered automatically.)	
Name of spouse or dependent (First, Last)	
Employer to complete or enrollment cannot be processed. Plan year start (MM/DD/YY) $01/01/21$ and end $12/31/21$ First payroll start date/	
OPTION 1 Health Care Account − FSA  YES I elect to contribute \$	
<ul> <li>OPTION 2 Dependent Care Account</li> <li>This pays for day care expenses for a dependent child, adult, or elder, so that you may work. Eligible services include: nursery school, nanny and/or before/after school care through age 12, day care for a disabled adult or child, elder day care for parent or dependent, day camp through age 12.</li> <li>YES I elect to contribute \$</li></ul>	×
YES On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e. health insurance).  I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect my taxable income will automatically be adjusted to reflect that change.  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 4 Additional Benefit (please insert description provided by your HR Department, if applicable) HSA	_
<ul> <li>YES I elect to contribute \$</li></ul>	
MPORTANT – 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 set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status at that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I acknowledge that I have received, read, and understand it is 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 pland that I will not seek reimbursement for expenses paid with the Card from any other ource. I understand that when using the take care* Card I must keep all receipts and that, on occasion, I made that I will not seek reimbursement for expenses paid with the Card from any other pland that I will not seek reimbursement for expenses paid with the Card and that when using the take care* Card I must keep all receipts and that, on occasion, I made that I will not seek reimbursement for expenses 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 me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).  USE OF PERSONAL INFORMATION – In addition to and without limiting in any way the rights my employer, the Plan, their service provider and their respective agents are paying and preventing fraud or misrepresentation. I further authorize my personal information (including, but not limited to benefit election wages, employment status, number of dependents, marital status and health and dependent child care information) as is reasonably required to administer the Plan (including valuating are processing requests for payment	nd the lan hay by
Employee signature Date	
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