

**SISC Flex Plan – Enrollment Form****Employer Code:** SIS**Plan Year:** 1/1/2026-12/31/2026 with Grace Period through 3/15/2027**Last Day to Submit Claims:** 3/31/2027

|                 |                       |
|-----------------|-----------------------|
| <b>Employer</b> | <b>Effective Date</b> |
|                 |                       |

**Employee Information** – Please write legibly to ensure proper enrollment

|                                                     |                     |                                                  |
|-----------------------------------------------------|---------------------|--------------------------------------------------|
| <b>First Name</b>                                   | <b>Last Name</b>    | <b>SSN</b>                                       |
|                                                     |                     |                                                  |
| <b>Home Address</b> (Street, City, State, Zip Code) |                     | <b>Date of Hire</b>                              |
|                                                     |                     |                                                  |
| <b>Date of Birth</b>                                | <b>Phone Number</b> | <b>E-mail Address (Mandatory for Debit Card)</b> |
|                                                     |                     |                                                  |

**Benefit Elections**

| <b>Section 125 Benefit</b>                                                                                                                                                                                                   | <b>Yes/No</b>                                               | <b>Annual Election</b> | <b># of Deductions</b> | <b>Paycheck Deduction</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------|------------------------|---------------------------|
| <b>Health Care Expense Account</b><br>Maximum of \$3,300.00 per plan year                                                                                                                                                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____               | _____                  | \$ _____                  |
| <b>Limited Purpose Health Care Expense Account</b><br>Maximum of \$3,300.00 per plan year<br><i>This account is for employees enrolled in a High Deductible Medical Plan and enrolled in a Health Savings Account (HSA).</i> | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____               | _____                  | \$ _____                  |
| <b>Dependent Care Expense Account (Daycare or Eldercare)</b><br>Maximum of \$7,500.00 per plan year<br>(or \$3,750.00 if you're married and filing taxes separately)                                                         | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____               | _____                  | \$ _____                  |

List any month(s) payroll deductions will not be taken for account(s) listed above. \_\_\_\_\_

**Debit Card & Direct Deposit**

|                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <b>Navia Debit Card</b> – You may use the card to pay for expenses directly from the funds in your Health Care, Limited Purpose and Dependent Care Expense Account. There is no cost for debit cards. Cards are valid for a 3 year period; if you've previously received a card then it will be reloaded with your new election. You must provide a valid e-mail address to use the card. | Automatic                                                                                                     |
| <b>Direct Deposit</b> – Reimbursements are electronically deposited into your bank account. If you've previously signed up for direct deposit with Navia your information will remain on file and you do not need to complete this section.                                                                                                                                               | <input type="checkbox"/> Checking    Routing #: _____<br><input type="checkbox"/> Savings    Account #: _____ |

**Signature**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health or Limited Purpose Expense Account reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Dependent Care reimbursements will be available only for qualifying day care and adult care expenses. I agree to notify the Plan Administrator if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Plan Administrator or Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and I have read the reverse page. I hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above. |             |
| <b>Employee Signature</b><br>X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Date</b> |
| <b>Employer Signature</b><br>X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Date</b> |

**Completed Enrollment Forms must be returned to Employer***Please see the reverse side for important information regarding the above benefits*

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## Additional Information

### Health Care Expense Account

- Reimbursement will only be available for qualifying medical care expenses as set forth in the Plan Document, Eligible Expense List, and Section 213 of the Internal Revenue Code. It is your responsibility to check the eligibility of an expense prior to enrollment.
- Group Medical Plan Premiums cannot be reimbursed through the Health Care Expense Account and may be deducted pre-tax through the Premium Only Plan. Therefore, do not include the cost of premiums in your Health Care Expense Account annual election amount.
- If the Plan Year is less than twelve (12) months, the plan limit may be prorated to be less than the \$3,300 calendar year limit mandated by the IRS.

### Limited Purpose Health Care Expense Account

- If you participate in a Health Savings Account (HSA) then you may not participate in the regular Health Care Expense Account. The Limited Purpose Health Care Expense Account is available for reimbursement of dental, vision, and orthodontia expenses only. See your Summary Plan Description for more information.
- If the Plan Year is less than twelve (12) months, the plan limit may be prorated to be less than the \$3,300 calendar year limit mandated by the IRS.

### Dependent Care Expense Account

- Reimbursement will be available only for qualifying day care and adult care expenses as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description.
- Participation in a Dependent Care Expense Account will require you to complete tax form 2441 when filing federal taxes. If your plan includes a Grace Period any amounts carried forward or forfeited during a taxable year should be entered in Line 13 of Form 2441. If you or your spouse are full-time students, please consult IRS Publication 503.
- If the Plan Year is less than twelve (12) months, the plan limit may be prorated to be less than the \$7,500 calendar year limit mandated by the IRS.

### Use-It or Lose-It

- You must claim all elected funds by the end of the run-out period. Money left in the plan after the end of the run-out period cannot be refunded to you; this is referred to as the Use-it or Lose-it rule.

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## Grace Period

- The grace period allows you to incur expenses against the prior plan year for 2 ½ months after the plan year ends (March 15, 2027). Expenses incurred after the end of the Grace Period are not eligible for reimbursement.

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## Claim Runout Period

- The claim runout period allows you to submit claims after the end of the plan year (March 31, 2027). Claims received after this period will be denied.

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## Direct Deposit

- All electronic funds transfers (EFT) will be initiated on the same day as the normal check reimbursement date.

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## Deductions

- SISC Flex Plan deductions will be deducted from your paycheck evenly throughout the plan year. You must indicate an annual election and a per paycheck deduction on your enrollment form. If you enroll in the plan after open enrollment then please divide your annual election by the remaining deductions in the plan year. The monthly and yearly elections may be adjusted slightly by SISC Flex Plan Administrator.
- Employees must enroll each year and make an election in order to participate.

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## Change in Event

- All elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in event. Please consult the plan document or summary plan description for a list of qualifying events.
- In the event of a change in event the change in election must be necessitated by and consistent with the change in event and the change must be acceptable under IRS Regulations.

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## Eligibility

- Independent contractors and self-employed individuals are not eligible to participate in the Plan. Self-employed individuals include: Sole Proprietors of their own business; General Partners in a general partnership and General Partners in a limited partnership; Limited Partners of partnerships with guaranteed payments; more than 2% Shareholders of an S corporation as well as the spouse, children, parents and grandparents of a more than 2% Shareholder; and non-employee Members of an LLC. It is your responsibility to determine your eligibility.
- Expenses must be incurred during the plan year and while you are an active participant in the plan. Any expense incurred prior to your effective date or after your termination date cannot be reimbursed.

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## Debit Card

- If you elect to use the card please keep in mind that you may still need to submit supporting documentation to verify that a charge is eligible. You will be notified via email if you have a charge that requires documentation. You can check your account online to view any outstanding charges or contact customer service.
- If you use the card for an ineligible expense or do not substantiate a charge your card may be temporarily suspended to prevent further use. The IRS provides the participant with 2 methods for correcting an ineligible or unsubstantiated charge: a) repay the plan for the amount of the expense, or b) request the substitution or offset of future out of pocket expenses.
- You will receive one card by default but you can request additional cards.
- If mid-year termination of plan the card will no longer be available to use.

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## Electronic Disclosure Notice

- By providing your e-mail address you consent to receive e-mail communications from the SISC Flex Plan Administrator, Navia, and subcontractors regarding the Plan.
- If you no longer wish to receive information electronically, you may withdraw consent at any time at no cost. To withdraw consent, please contact Navia.
- You have a right to receive a paper version of an electronically furnished document at no cost.
- To access documents, you must have Adobe Reader. A link to download this software will be provided with all electronic documents provided.