



Taxable Compensation Redirection Agreement

Employee Name: _____ Employer: _____

Do you wish to have the AmeriFlex Convenience Cardsm issued for a spouse or a dependent? Yes No
(Only applicable if your employer has chosen this option)

Please read the following section very carefully.

If you wish to have an AmeriFlex Convenience Cardsm issued for a spouse or dependent, please note the following IRS regulations advising who is eligible before completing this page:

- 1- For federal tax purposes, a "spouse" is defined as, "...a person of the opposite sex who is a husband or wife." Same sex domestic partners are not considered spouses for purposes of FSA administration. A person residing in the employee's home, who the employee provides over half of their support, who is not the employee's spouse, under applicable state law and is not a family member, is considered a dependent under Internal Revenue Code 152.
- 2- For federal tax purposes, a "dependent" includes any relative of the participant for whom the participant provides over half of their support for the calendar year. "Relative" includes children, parents, stepchildren, stepparents, siblings, aunts, uncles, cousins, and in-laws of the participant. Relatives do not need to reside with the participant in order to be dependents, nor do they need to be of a certain age or infirmity; they need only to be persons for whom the participant has provided over half of their support.

Spouse Name: _____ Soc Sec Number: ____ - ____ - ____ Date of Birth ____ / ____ / ____

Address to issue card (if different than participant) _____

Telephone: (____) ____ - ____

All Dependents must be over the age of 18 in order to receive the AmeriFlex Convenience Cardsm.

Dependent Name: _____ Soc Sec Number: ____ - ____ - ____ Date of Birth ____ / ____ / ____

Address to issue card (if different than participant) _____

Telephone: (____) ____ - ____

Dependent Name: _____ Soc Sec Number: ____ - ____ - ____ Date of Birth ____ / ____ / ____

Address to issue card (if different than participant) _____

Telephone: (____) ____ - ____

***Please return to your Benefits/Human Resource administrator**