

Health Care & Dependent Care Flexible Spending Account (FSA) Enrollment Form

Employee First Name:			Employee Last Name:		
Street Address:			Social Security #:		Plant Location:
City:	State:	Zip:	Pay Frequency: ☐ Weekly ☐ Semi-Monthly ☐ Monthly		

Under the Crown Cork & Seal Company, Inc. Cafeteria Plan (Plan), I may elect to have my compensation reduced by the amount(s) indicated below and to have such amount(s) contributed to the Plan on my behalf on a pre-tax basis in order to purchase the medical benefits and/or dependent care benefits indicated (*FSAs may slightly reduce your future Social Security benefits by lowering your wage base*). **Please complete Section (1), Section (2) and Section (3) whether or not you want to participate in both FSAs.**

SECTION (1): HEALTH CARE FSA FOR MEDICAL, VISION & DENTAL EXPENSES

- ☐ I have been offered the opportunity to participate in the Health Care FSA program but I **do not wish to enroll** in the FSA for qualifying health care expenses.
- ☐ I elect to have an FSA for qualifying health care expenses. I elect to have \$ _____ deducted each pay period from my pay and contributed to the account on my behalf. The minimum amount that can be contributed to the account during any calendar year is \$52.00. The maximum amount that can be contributed to the account during any calendar year is **\$3,400.00** subject to certain IRS limits. My annual contribution goal is \$ _____. I agree to have my compensation reduced by the amount set forth above, effective January 1. The amount by which my compensation is reduced shall be credited to a Health Care FSA established on my behalf and may be used to reimburse me for qualified health care expenses which are not reimbursed by any medical, prescription drug, vision or dental plan.

SECTION (2): DEPENDENT CARE FSA FOR DEPENDENT DAY CARE EXPENSES

- ☐ I have been offered the opportunity to participate in the Dependent Care FSA program but I **do not wish to enroll** in the FSA for qualifying dependent care expenses.
- ☐ I elect to have an FSA for qualifying dependent day care expenses. I elect to have \$ _____ deducted each pay period from my pay and contributed to the account on my behalf. The minimum amount that can be contributed to the account during any calendar year is \$52. The maximum amount that can be contributed to the account during any calendar year is **\$7,500** (\$3,750 for married couples filing separate tax returns). My annual contribution goal is \$ _____. I agree to have my compensation reduced by the amount set forth above, effective January 1. The amount by which my compensation is reduced shall be credited to a Dependent Care FSA established on my behalf and may be used to reimburse me for qualified dependent care expenses which I may incur (**Note: certain state taxes are not reduced for this election**). I understand that if I am married, my spouse and I must be working or my spouse must be a full-time student or incapable of self-care for me to participate in the Dependent Care FSA.

SECTION (3): AFFIRMATION

I cannot change or revoke my selections and premium contributions as of any date prior to the next January 1st, unless I have a qualified change in family status (please refer to the Internal Revenue Code for a description of qualified changes in family status). Any unused account balance remaining at the end of the Plan year **will be forfeited**.

The plan administrator may reduce or cancel the amount of my compensation reduction (if any) or otherwise modify the above elections in accordance with the Plan if it believes it advisable in order to satisfy certain provisions of the Internal Revenue Code. The reduction in my cash compensation authorized under this Enrollment Form will be in addition to any reductions under any other agreements or benefit plans.

In the event of termination of my employment, my contributions will stop and I will have three (3) months from the date of my termination to submit expenses incurred prior to my termination date. Any remaining balance **will be forfeited**. (Under certain circumstances, you may be eligible for COBRA continuation coverage with respect to your Health Care FSA for the remainder of the plan year. Please refer to your Summary Plan Description for more detailed information.)

I must complete and return this form before the enrollment deadline to the **Crown Insurance Department, 770 Township Line Road, Yardley PA, 19067** or Pat.McCann@crowncork.com. If I fail to do so, I will be treated as if I elected not to participate for the next Plan year.

By signing below, I authorize the Company to make payroll deductions in an amount equal to the total of what I elected above.

I understand that Crown Cork & Seal Company, Inc. (Crown) reserves the right to modify, suspend, change, or terminate the Crown Cork & Seal Company, Inc. Cafeteria Plan at any time.

Employee's Signature: _____ Date _____

Employer's Signature: _____ Date _____

The employee should keep a copy of this form for his or her records.

Flexible Spending Accounts Frequently Asked Questions



1. What is a Flexible Spending Account?

A Flexible Spending Account ("FSA") provides you with an opportunity to set aside pre-tax dollars from your pay to cover eligible expenses. There are two accounts:

- The Health Care FSA
- The Dependent Care FSA

Under government rules, any contributions to an FSA not used for qualified expenses during the applicable year and grace period **must be forfeited**. It is important to plan carefully and be sure your expenses will qualify for reimbursement before deciding to enroll in an FSA.

Qualified expenses may be incurred from January 1st through March 15th of the following year.

2. What expenses qualify for reimbursement from my Health Care FSA?

Medical expenses eligible for reimbursement must be primarily to alleviate or prevent a physical or mental disability, injury or illness. Expenses incurred for items that are merely beneficial to general health, such as vitamins or exercise equipment, are not qualified expenses. Medical expenses must be considered tax-deductible by the IRS to be FSA-eligible. See IRS Publication 502 for more information. If an item is not clearly identified as a qualified medical expense in IRS Publication 502, Crown will not allow reimbursement from your FSA.

The expenses may be for you, your spouse, or someone you claim as a dependent on your federal income tax return regardless of whether or not you or your family members are covered by Crown's health care programs. Expenses cannot be eligible for reimbursement by another plan, such as medical or dental insurance.

3. What expenses qualify for reimbursement from my Dependent Care FSA?

Qualified expenses include care for a child under age 13 or care for a spouse, or other dependent, who is physically or mentally incapable of self-care.

Common examples of qualified dependent care expenses include: 1.) fees for day care or nannies whose duties include child/elder care, and 2.) fees for before- and after-school programs, provided the expenses are itemized separately from tuition expenses. The IRS defines what child and dependent care expenses qualify for the special tax treatment available through an FSA. See IRS Publication 503 for more information.

4. How do I enroll in a Flexible Spending Account?

You may only enroll in an FSA during annual open enrollment for the upcoming calendar year. You must re-enroll each year that you want to participate in an FSA. See your Human Resources representative for an FSA Enrollment Form or contact Insurance@crowncork.com for assistance.

You make a separate election for the Health Care FSA and the Dependent Care FSA. Amounts may not be transferred from one FSA to the other. For example, the amounts you contribute to the Dependent Care FSA may not be used to pay for eligible health care expenses. Likewise, the amounts you contribute to the Health Care FSA may not be used to pay for eligible dependent care expenses.

The annual contribution limits in effect as of January 1, 2027 are:

- \$3,400 for the Health Care FSA
- \$7,500 for the Dependent Care FSA (or \$3,750 if married filing separately)

5. How do I get reimbursed from my FSA?

Expenses must be paid out-of-pocket, and you can request reimbursement using an FSA Reimbursement Request form. The form must be accompanied by itemized receipts and an Explanation of Benefits ("EOB") for medical, dental or vision claims that are eligible for insurance coverage. For a dependent care claim, the tax identification number of the provider is required. If the claim is acceptable for reimbursement, Crown will issue the payment from your FSA in the same manner you receive wages (e.g., direct deposit). If the claim is not acceptable, you will be notified of the reason why (e.g., not a qualified expense or supporting documentation missing)

Claim reimbursement forms are available on the Insurance page on crownnet or from your Human Resources Representative. Per IRS regulations, you may be reimbursed from your Health FSA up to the amount of your annual contribution at any time, and you may be reimbursed from your Dependent Care FSA only up to the balance of your contributions to date.

6. What happens if my employment ends?

If your employment with the Company terminates for any reason, you may only submit expenses that have been incurred up until the date of your termination. Any requests for reimbursement must be submitted within three months of your termination date.

You may continue to make contributions to your Health Care FSA on an after-tax basis if you are entitled to and elect COBRA coverage. You cannot continue to contribute to your Dependent Care FSA even if you elect COBRA coverage. Claims incurred after your termination date are FSA-eligible while you remain covered under COBRA and continue to make Health Care FSA contributions.

7. What happens to my contributions during a leave of absence?

If you are on a leave of absence and receiving pay from Crown, such as short-term disability, your FSA contributions will continue. If you are on an unpaid leave of absence, additional deductions will be taken once your pay resumes to cover your missed contributions.

If your unpaid leave is covered by the Family and Medical Leave Act of 1993, as amended, you have the option to resume your contributions at their original amount without making missed contributions upon your return to work. To exercise this option, you must contact the Corporate Insurance Department prior to returning to work, and your expenses reimbursed to date cannot exceed the new prorated annual contribution amount.

8. Can I change my FSA election during the year?

No. Once you have enrolled in an FSA, you cannot change or stop contributions during the year. If you experience a qualifying event, such as marriage or the birth of a child, you may revoke or change your contribution but only if you are already participating in an FSA. The change must be requested within 30 days of the qualifying event date.