Flexible Spending Account Enrollment Form

PRO-FLEX ADMINISTRATORS LLC

Step 1: Participant Information

*=Required Fields

*Employer Name (Do not abbreviate):	*Department: SCHOOL DEPARTMENT
*Participant Name (First, MI, Last):	*Social Security Number: ___ - __ - ____
*Participant Mailing Address:	Email Address (If provided, all notifications will be sent via email):
*City:	*State: *Zip:
Day Telephone: ___ - ___ - ____	*Birth Date (mm/dd/yyyy):
*Hire Date (mm/dd/yyyy):	

*Payroll Cycle:

- ☐ Weekly
- X Bi-Weekly
- ☐ Semi-Monthly
- ☐ Monthly
- ☐ Other ______________

Date of first payroll withholding: 09/21/2018

Step 2: Spouse and Dependent Information

*Name (Last, First)	*Date of Birth	*Social Security Number
Spouse:		
Dependent:		
Dependent:		
Dependent:		

Step 3: Election

Account Type	Election Amount
Medical Expense Account	________ Annually
Dependent Care Reimbursement	________ Annually

Minimum Reimbursement amount for manual check is $25

Step 4: Authorization or Refusal

I hereby elect the benefits indicated above. I have read and understand the enrollment materials (flex brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e. marriage, divorce, birth). I understand that if I am enrolled in a Health Savings Account (HSA) that I cannot enroll in the Medical FSA, and that I can only enroll in the Limited Purpose FSA if my employer offers this account.

SIGNATURE OF PARTICIPANT ______________________________ **DATE** ________________

BENEFITS EFFECTIVE DATE 07 / 01 / 2018