

Flexible Benefit Plan Participation Form



Employer _____

Employee Name _____

Social Security Number (at least last four digits;
full number required for new participants)

Mailing Address _____

Email: (required for online account access) _____

Birth Date _____

Flexible Spending Accounts

Request to PARTICIPATE

Medical / Dental / Vision Care

The cost paid by you or your dependents for medical, vision or dental care that is not reimbursed by insurance.

Dependent Care

Employment-related custodial care for qualifying dependents (children age 12 and under; or dependent, disabled adults).

Request to WAIVE

The Flexible Benefit Plan has been explained and I elect to waive participation in Flexible Spending Accounts. I understand that without a Change in Status or other Qualifying Event described in the Plan, my next opportunity to enroll will be at the start of the next plan year; if not changed, this waiver will continue in effect indefinitely.

Plan Year Benefit Elections

\$ _____ / Plan Year
Employer-set minimums and maximums apply.

\$ _____ / Plan Year
IRS Family Maximum \$5000/yr.

Employer: Please complete

_____ Med FSA Amount/Pay Pd.

_____ Dep FSA Amount/Pay Pd.

_____ First Payroll Date Impacted

_____ Initial to Indicate Approval

Direct Deposit Signup

(If offered by your plan)

Type of Account:

Checking

Savings

Please check one:

I am signing up for Direct Deposit for the first time.

I would like to change my account information.

Important: If you are re-enrolling for a new plan year and you already receive Direct Deposit reimbursements, DO NOT complete this section unless your bank information has changed. You may also add or change Direct Deposit information any time during the plan year by logging into your account online at my.ProBenefits.com.

Please tape a Voided Check (not deposit slip) here.

A voided check supplies the account numbers and routing information required by the bank to establish your Direct Deposit arrangement. (Deposit slips sometimes do not include all needed information.)

By signing below I certify that I have read the Flexible Spending Accounts Acknowledgments and, if applicable, the Debit Card Acknowledgments and/or the Direct Deposit Reimbursement Authorization Agreement on the reverse of this page. I agree to the terms of participation listed in this guide. I authorize my employer to adjust my compensation by the amount of my Benefit Elections shown above.

Signature: _____ Date: _____