



Flexible Benefit Plan Enrollment Form

Group Name: _____ Group Number _____

Last Name:	First:	MI:	Soc. Sec. No.
Street Address	City	State	Zip
E-mail Address:		Home Phone () -	
Birthdate (mm/dd/yyyy)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced			

Spouse Information			
Last Name:	First:	MI:	Birthdate (mm/dd/yyyy)

Other Dependents		
Name	Birthdate (mm/dd/yyyy)	Relation

I am paid: Weekly Bi-Weekly Monthly Semi Monthly | Hire Date (mm/dd/yyyy)

Debit Card Agreement

I understand the following debit card rules:
According to the IRS guidance, Revenue Ruling 2003-43 upon every use of the Debit Card:

- 1) The card will only be used for eligible health care expenses. If ineligible expenses are purchased I will be required to reimburse the Plan.
- 2) The expense paid with the card cannot be reimbursed under any other plan covering health benefits.
- 3) The card will only be used for point of service claims. I will not pay for balance due amounts on my card.
- 4) I will acquire and retain sufficient documentation and receipts for any expense paid with the card.
- 5) Reimbursement for health costs are processed only if they originate with certain vendors having health care related Merchant Codes.
- 6) Upon request, I will immediately submit the required documentation and receipts to Professional Benefit Administrators, Inc.
- 7) If I fail to produce the required documentation and receipts, I authorize my Employer to collect from me personally or withhold such funds from my payroll.
- 8) I understand that one debit card will be issued to the member. Additional cards for dependents age 18 and older may be requested free of charge. There will be a \$10.00 replacement fee for lost or stolen cards. The fee will be deducted from my Medical Flex Spending Account balance.

Automatic Rollover

I elect Automatic Reimbursement of medical and dental claims processed by PBA
 With this feature we will roll your share of the claims such as deductibles, office visits, co-pays and co-insurance to your Flex account and you will automatically be reimbursed without submitting a claim. All claims for services not covered under the group plan should be submitted directly to Professional Benefit Administrators.
 Do you currently participate in the employer sponsored group health insurance? Yes No
If this section is not complete, you will not be put on the rollover. The automatic rollover option cannot be chosen if you have double coverage with your spouse's insurance as it will cause you to violate the law.

Payment Method

Select the method in which you would like to be reimbursed when the debit card is not used:
 Direct Deposit (Please complete Direct Deposit Form) Check

Salary Redirection Agreement And Election Of Benefits

As a Participant in The Flexible Benefit Plan, I understand that I may redirect a portion of my pay to provide benefits under the Plan. The amount of my redirection will be withheld from my paycheck each pay period. Therefore, my employer is hereby authorized to redirect my compensation in such an amount that is sufficient to provide the benefits I have elected below. I hereby elect the following benefits which are available under the Plan and designate the following amounts for each benefit I have selected.

	Annual Amount	Amount Per Pay Period
Medical Expense Reimbursement Account	\$	\$
Dependent Care Reimbursement Account	\$	\$

I have read and understand the items on the front and back of this form. The election made shall apply to the Plan Year 9/1/10 – 8/31/11.

Participant's Signature	Date	Accepted by the Administrator
To be completed by Employer: Effective Date (mm/dd/yyyy)	First Ded. (mm/dd/yyyy):	Location

Note: There may be limits on the amounts which can be used for certain benefits. You should review your Summary Plan Description and ask your Administrator if you have any questions. Also, to complete the information on the front page, first determine your annual contribution for each benefit selected. Then, divide that amount by the number of pay periods remaining in the Plan Year and write that amount in the amount per pay period column.

With regard to my salary redirection agreement and my election of benefits, I understand that:

- I may **not** change elections during the Plan Year unless there is a change in my family status (e.g., marriage, divorce, death of my spouse or child, adoption or birth of my child, a change in the employment status of my spouse, or emergency medical leave).
- The Administrator is authorized to adjust the amount of my salary redirections and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code.
- My election of salary redirections and benefits will remain in effect only for the Plan Year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election not to participate in the Plan for that Plan Year.
- Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year.

I hereby apply for participation in the above referenced Plan. I acknowledge that I have received a Summary Plan Description and agree to abide by the rules and requirements under the Plan.

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek the payment of benefits under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

Name

Address

Relationship

DECLINATION

The benefits of the plan have been thoroughly explained to me and **I DECLINE TO PARTICIPATE.**

Signature

Date