

# Special Flex Benefit Plan Participation Form

**Employer:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_ **Social Sec#:** \_\_\_\_\_  
First Name Last Name

**Mailing Address:** \_\_\_\_\_  
Street City St. Zip

**Birth Date:** \_\_\_\_\_ **Hire Date:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
ProBenefits will email Claims & Payment Verifications

## Flexible Spending Accounts

**Request to PARTICIPATE**

## Plan Year Benefit Elections

### 1. Medical/Dental/Vision or Limited Dental/Vision - Choose **ONE** (A, B or C):

**A. Employee Only Medical/Dental/Vision Care**  
 The cost paid by you for annual deductibles, co-payments, eye care, dental care, routine care, which is not reimbursed by insurance. The costs incurred by your spouse or dependents are not eligible for reimbursement.

\$ \_\_\_\_\_ / Plan Year  
[Employer-set minimums and maximums apply]

**B. Employee Plus Child(ren) Medical/Dental/Vision Care**  
 The cost paid by you or your children for annual deductibles, co-payments, eye care, dental care, routine care, which is not reimbursed by insurance. The cost incurred by your spouse is not eligible for reimbursement.

\$ \_\_\_\_\_ / Plan Year  
[Employer-set minimums and maximums apply]

**C. Limited Dental/Vision Care**  
 The cost paid by you or your dependents for dental care or vision expenses which is not reimbursed by insurance. Regular Medical Expenses are not eligible for reimbursement.

\$ \_\_\_\_\_ / Plan Year  
[Employer-set minimums and maximums apply]

### 2. Dependent Care

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

\$ \_\_\_\_\_ / Plan Year  
[IRS Maximum \$5000/yr]

<b>This section must be completed by your employer:</b>
<b>Med FSA Amount/Pay Pd.</b>
<b>Dep FSA Amount/Pay Pd.</b>
<b>First Payroll Date Impacted</b>
<b>Initial to Indicate Approval</b>

### ACKNOWLEDGMENTS:

- I cannot change or revoke my elections prior to the start of the next plan year, unless I have a Change in Status or other event described in the Plan. (Non-exhaustive examples of Changes in Status: marriage, divorce, birth or adoption of a child, termination of spouse's employment.)
- My portion, if any, of insurance premiums for eligible employer-sponsored insurance plans elected for myself and my dependents will be automatically pre-taxed unless I sign a Pre-Tax Waiver form provided by my employer. My employer may adjust pre-tax premiums if rates change during the year, but I may not be able to change my election during the Plan Year.
- Signing this form does not initiate my coverage under any insurance policy.
- Participation in this Plan may mean paying less Social Security tax, which could reduce my future Social Security benefits.
- My Plan Year Benefit Elections may be slightly rounded, if necessary, to allow per-pay-period salary reductions.
- Unused amounts remaining in Flexible Spending Accounts for the Plan Year and applicable runout period(s) will be forfeited.
- I can only submit claims for expenses incurred during the Plan Year while I am an active participant in the Plan. Such reimbursement requests must be submitted with appropriate documentation (claim form and provider receipts) no later than 90 days after the end of the Plan Year or 90 days after termination of Plan participation, whichever comes first.
- If my Employer offers and I receive a Flex Debit Card, I certify I will only use the card for eligible expenses as outlined in the Cardholder Agreement.
- My benefit account(s) and claim data may be maintained on a computer system providing automated access.
- Due to privacy concerns, ProBenefits will discuss claim information only with me as the participant.
- Enrollment in the Medical Flexible Spending Account listed covers me and my eligible dependents, if any. I understand that FSA enrollment may impact my eligibility, or eligibility of my spouse or dependent(s), for a Health Savings Account (HSA). I also understand that I cannot change or reduce my Medical FSA during the plan year in order to enroll in an HSA. *Note: To enroll in an "Employee-Only" or "Employee-Plus-Children" Medical FSA or a "Limited" FSA (covering only dental/vision expenses), use this form.*
- This document provides accurate, general information about a Flexible Benefit Plan. For more specific information, I will review my Plan's Summary Plan Description (SPD).

**I agree to the terms of participation on this form and in related Plan Documents. I authorize my employer to adjust my compensation by the amount of my Benefit Elections shown above.**

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If re-enrolling for a new plan year and already on Direct Deposit reimbursement, no new DD form is required.*