

**MEDICAL FLEXIBLE SPENDING ACCOUNT PROGRAM
ENROLLMENT FORM**



AGENCY NAME:		PLAN YEAR: 20__	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER (MUST BE PROVIDED)	
EMPLOYEE LAST NAME:		FIRST NAME	MI		
STREET ADDRESS		CITY	STATE	ZIP	
HOME PHONE NUMBER		HOME EMAIL ADDRESS		DATE OF BIRTH	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		DATE OF HIRE	EMPLOYEE ID#	EMPLOYEE RECORD#	
PAYROLL CYCLE <input type="checkbox"/> BIWEEKLY		<input type="checkbox"/> SEMI-MONTHLY	<input type="checkbox"/> MONTHLY	<input type="checkbox"/> FIVE PAY	
DATE OF FIRST PAYROLL WITHHOLD		MONTH	DAY	YEAR	

The following employees are not eligible to join the Medical Flexible Spending Account:

- Per diem, sessional, durational, temporary or seasonal workers, adjunct faculty members, graduate assistants, and employees who are working, or are expected to work, less than 0.5 full time equivalent.
- Employees on unpaid leave for any reason. • Former employees and rehired retirees.

******ENROLLMENT SUBJECT TO ELIGIBILITY VERIFICATION******

OPEN ENROLLMENT ELECTION AMOUNT	\$ _____ ANNUAL AMOUNT (\$520-\$2500)
MID YEAR ELECTION/CHANGE ELECTION AMOUNT	\$ _____ REVISED ANNUAL AMOUNT
For Mid Year Enrollment Status Election, please check applicable event:	
<input type="checkbox"/> NEW HIRE <input type="checkbox"/> MARRIAGE <input type="checkbox"/> BIRTH <input type="checkbox"/> DIVORCE <input type="checkbox"/> ADOPTION <input type="checkbox"/> DEATH <input type="checkbox"/> SPOUSE EMPLOYMENT CHANGE <input type="checkbox"/> OTHER	
I elect to participate with the pre-paid benefits card. <input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby authorize the State of Connecticut to reduce my gross salary before federal, state and Social Security taxes are withheld by the total annual election amount elected above and affirm my understanding that:

- *My election is irrevocable and can not be changed during the plan year, unless I experience a qualifying change in family status, as defined by the Internal Revenue Code Section 105. *Any election changes must be made within 31 days of the qualifying event*
- *Changes will be processed on the check date following receipt of the Enrollment/Change Form pursuant to the Payroll Cut-off Date Schedule.
- *Money in the MEDFLEX account may only be used to reimburse expenses for eligible products and services actually incurred during the plan year.
- *I am responsible for any fees associated with the use of the benefits debit card, not otherwise paid for by my employer and that the pre-paid benefits debit card will be inactivated upon termination of employment or if I do not comply with the provisions of the Plan/card.
- *My deductions will be pro-rated over the number of pay cycles I actually work during the Plan Year.**

I certify that the above information is correct and true and that I will only use my MEDFLEX to pay for IRS qualified expenses for myself and my eligible dependents and that I will not deduct on my tax returns any expenses reimbursed by my MEDFLEX. I agree that I will collect and maintain expense documentation for claim substantiation. **I understand that any amounts remaining in my MEDFLEX account that have not been used for eligible expenses incurred during the plan year (January 1 – December 31) must be claimed by March 31 of the following year or they will be forfeited in accordance with plan provisions and Internal Revenue Code requirements.**

Employee Signature _____ Date _____

KEEP A COPY FOR YOUR RECORDS

MAIL OR FAX COMPLETED FORM TO: Progressive Benefit Solutions, LLC (PBS), 23 Maiden Lane, North Haven, CT 06473
FAX: (203) 974-4890 Phone: 1-866-906-8023