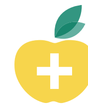
Flexible Benefit Plan Participation Form



ProBenefits
The benefit of trust.

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).

Plan Year Benefit Elections

$ ____________ / Plan Year
$1,500 maximum set by employer

$ ____________ / 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

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.

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 a new participant in the FSA plan, once your account is set up with ProBenefits, please log in to your account online at my.ProBenefits.com to enter your direct deposit information.

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 in to your account online at my.ProBenefits.com.

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: ____________