Flexible Benefit Plan Participation Form

Please print clearly!

Employer: _____

Employee Name: _____ (First Name / Last Name) **Social Sec#:** _____

Mailing Address: _____ (Street / City / St. / Zip)

Birth Date: _____ **Hire Date:** _____ **Email:** _____ (ProBenefits will email Claims & Payment Verifications)

Flexible Spending Accounts

☐ **Request to PARTICIPATE**

A. Medical / Dental / Vision Care
The cost paid by you or your dependents for medical, vision or dental care which is not reimbursed by insurance.

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

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

☐ **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.

Flex Card - ONLY for Initial Signup *(If offered by your plan)*

☐ **I want a Flex Card.** IMPORTANT: If you already have a ProBenefits Flex Card, DO NOT complete this section. You will automatically receive a new card in the mail when your current card expires. If you and/or your dependent have lost your card(s) or you skipped a year of FSA participation, please contact ProBenefits.

Employer: Is employee a participant in your group health plan? ☐Yes ☐No

Home Phone #: _____ Mother's Maiden Name: _____ (For security purposes only)

Additional Card for Spouse or Dependent: _____ (21 characters maximum including spaces) Relationship: _____ (i.e., Spouse or Child)

Weekly 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 www.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 Flex 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:** _____

ProBenefits
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Acknowledgments

Flexible Benefit Plan and Flexible Spending Accounts

1. 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.
2. 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 Qualifying Event described in the Plan. The Summary Plan Description ("SPD") includes a full explanation.
3. Signing this form does not initiate my coverage under any insurance policy.
4. My Plan Year benefit elections may be slightly rounded, if necessary, to allow per-pay-period salary reductions.
5. I understand that the Annualization Rule (Uniform Coverage Rule) applies to the Medical/Dental/Vision FSA and entitles me to reimbursement up to the full annual election at any time during the plan year once eligible expenses are incurred. I understand the Annualization Rule does not apply to the Dependent Care FSA, and that Dependent Care reimbursements cannot exceed contributions for the plan year to date. This means that eligible childcare expenses can only be reimbursed as contributions are deducted from my pay, and even though an expense may be eligible and approved, reimbursement will not be made until sufficient funds are contributed.
6. Unused amounts remaining in Flexible Spending Accounts for the Plan Year and applicable runout period(s) will be forfeited.
7. 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.
8. My benefit account(s) and claim data may be maintained on a computer system providing automated access.
9. Due to privacy concerns, ProBenefits will discuss claim information only with me as the participant.
10. Participation in this Plan may mean paying less Social Security tax, which could reduce my future Social Security benefits.
11. 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), see your benefits administrator for a special form.*
12. This document provides general information about a Flexible Benefit Plan. For more specific information, I will review my Plan's SPD.
13. Due to IRS non-discrimination rules for flex plans, in some circumstances the pre-tax elections of Highly Compensated Employees or Key Employees must be adjusted mid-year to meet IRS compliance testing guidelines. If you are deemed to be a Highly Compensated Employee or Key Employee, your election may be reduced or discontinued in such a circumstance. If so, the benefits administrator will provide notice and further details.

Flex Card (If offered by your plan)

After completing the Flex Card - Initial Signup on the Plan Participation Form, as an FSA participant you will receive a *my*SourceCard™ MasterCard® and agree to use it according to these Acknowledgments and the Cardholder Agreement that will be provided with the card.

1. I understand that the Flex Card is restricted to certain merchant categories and approved IIAS vendors and is not accepted at all MasterCard® authorized locations.
2. I understand that I may not obtain a cash advance with the card at any merchant, bank or ATM.
3. I understand that the card is to be used *exclusively* for Qualified Expenses as defined by the plan(s) in which I participate. If the card is used for an expense that is not a Qualified Expense, I understand that I am indebted to my employer and must repay the full amount of the non-qualified expense. Repayment for non-qualified expenses may be in the form of an offsetting claim, a personal check, electronic draft from my personal checking or savings account, a post-tax deduction from my paycheck, or other options established by my employer.
4. I acknowledge that IRS rules require me to save all invoices and receipts related to any expense paid with the card. I agree that, upon request, I will submit these documents for review by the Plan Service Provider. I understand that failure to submit the receipt(s) in a timely manner will cause the expense to be treated as a non-qualified expense and may cause my card to be suspended.
5. I understand that I may be assessed a $10.00 replacement card fee if I lose or misplace my card(s). I also understand that if I request more than two cards (one for myself and one for my spouse or a dependent), I may be assessed a $10.00 fee for each additional card.

Direct Deposit Reimbursement Authorization Agreement (If offered by your plan)

1. I hereby authorize ProBenefits, Inc. (hereinafter "Plan Service Provider") to initiate credit entries (electronic and otherwise) and, if necessary, debit entries and adjustments for any erroneous credit entries to my Personal Bank Account in the financial institution named (hereinafter "Financial Institution").
2. This authority is to remain in force until the Plan Service Provider has received written notification from me of its termination in such time and manner as to afford Plan Service Provider and Financial Institution a reasonable opportunity to act on it. I can discontinue this arrangement at any time and receive reimbursements monthly by check, if offered by my plan.
3. I acknowledge that my Flexible Spending Account (FSA) information will be available to me 24 hrs/day by internet (www.ProBenefits.com), and that I will not receive written verification each time a reimbursement payment is made.

Please complete and sign the Plan Participation Form on the reverse of this page.