CONSOCIATE

ProFlex Participation Form

HR/Payroll Use Only
Effective Date ______________
First Contribution Date ______________
# of pay periods (circle one)
12 18 24 26 52 Other ____

General Information

Plan year or plan effective date		
Employer name	Date of Birth (Month/Day/Year)	
Employee Name (First, Middle, Last)	Social Security No.	
Department	E-mail	
Home address		
City	State	Zip
Home phone ( )	Work phone ( )	

I authorize the employer listed above to make salary reduction contributions(s) on my behalf to the following sub account(s):

Option I: Premium Savings Account

❍ Yes ❍ No

Option II: Healthcare Flexible Spending Account

❍ I elect to contribute: $__________ per pay

$__________ annual

If available: ❍ I elect Automatic Claim Reimbursement (Not available with Debit card. (Please check with Employer HR Dept. for availability)

❍ I elect Debit Card (Not available with Automatic Claim Reimbursement. (Please check with Employer HR Dept. for availability)

Option III: Dependent Daycare Account

❍ I elect to contribute: $__________ per pay

$__________ annual

Note: (Maximum amount per calendar year is the lesser of; (1) $5,000 for married filing joint, or $2,500 for married filing separate; (2) your spouse's total annual compensation; or (3)1/2 of your total annual compensation. If you are single, the maximum amount is $5,000.)

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash or used in a later plan year. A copy of the Summary Plan Description is available upon request.

Employee Signature______________________________ Date ______________

WAIVER

I have reviewed the Flexible Spending Account Program offered by my employer and elect not to have eligible expenses paid with pre-tax dollars under the following accounts: 1. Premium Savings Account; 2. Healthcare Flexible Spending Account and 3. Dependent Daycare Account. I further understand that I will not have an opportunity to enroll in the Flexible Spending Account Program until the next plan year, unless I meet the qualifications as set forth by IRS guidelines.

Print Name______________________________ Date ______________

Employee Signature______________________________