Flexible Spending Account Enrollment Form

PRO-FLEX ADMINISTRATORS LLC

Step 1: Participant Information

*=Required Fields

DeSoto Memorial Hospital
*Employer Name (Do not abbreviate)

*Department

*Participant Name (First, MI, Last)

*Social Security Number

*Participant Mailing Address

Email Address (If provided, all notifications will be sent via email)

*City

*State

*Zip

Day Telephone

*Birth Date (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

Step 2: Spouse and Dependent Information

	*Name (Last, First)	*Date of Birth	*Social Security Number
Spouse:			
Dependent:			
Dependent:			
Dependent:			

Step 3: Election

Account Type	Election Amount
Medical Expense Account	_____ Annually
Dependent Care Reimbursement	_____ Annually

Minimum Reimbursement amount for manual check is $25

Step 4: Authorization or Refusal

I hereby elect the benefits indicated above. I have read and understand the enrollment materials (flex brochure, enrollment form, daycare form, direct deposit form and claim form) and I authorize my employer to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until the next plan year, except under the limited circumstances that are described in detail in the SPD that I have received from my employer (i.e. marriage, divorce, birth). I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the period of coverage will be forfeited in accordance with the current plan provisions and tax laws.

SIGNATURE OF PARTICIPANT_____ **DATE** _____

Step 5: Employer Authorization

01/01/2023
* Benefit Effective Date

01/05/2023
*Date of first payroll withholding

☐ Weekly ☐ Semi-Monthly ☑ Bi-Weekly ☐ Monthly ☐ Other _____

*Payroll Cycle

SIGNATURE OF EMPLOYER_____ **DATE** _____