P&A Group

Flexible Spending/Cafeteria Plan Enrollment Form

Employer Name: **Plan Year: 20_____**

Last Name	First Name	M.I.	☐ Male ☐ Female Soc. Sec. No. **(Must be provided)**
Street Address	City	State	Zip Code
Home Phone Number ( )	Date of Birth	Date of Hire	Division of Company: ☐ Single ☐ Family
Email Address:			
Payroll Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____ Date of first payroll withhold; Month _____ Day _____ Year_____			

Spouse Name (First, M.I.)	Date of Birth	Dependent Name (First, M.I.)	Date of Birth
Dependent Name (First, M.I.)	Date of Birth	Dependent Name (First, M.I.)	Date of Birth
Dependent Name (First, M.I.)	Date of Birth	Dependent Name (First, M.I.)	Date of Birth

Account Type (Note: Not all accounts may apply to your company)	**Election Amount**	**Short Plan Years / Mid-Year Enrollees** (*Please note below*)
Medical Expense Reimbursement (example: Doctor co-payments, eye glasses)	_____ Annual	**Your election amount will be the <u>full amount</u> you are electing even if you will not be enrolled in the plan(s) for a full 12 months.** **This amount will <u>not</u> be prorated for your short plan year**
Dependent Care Assistance	_____ Annual	
Individual Premium Reimbursement (example: Dependent/student COBRA premiums)	_____ Annual	
Adoption Assistance	_____ Annual	

Minimum reimbursement amount for manual check is $25

<u>Please note</u>: For any enrollment/change forms effective outside of the initial plan year, the effective date will correspond with the next payroll period after the signature date. Claims reimbursement will be made only for expenses incurred on or after the signature date.

AUTHORIZATION

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** _____

Please return all enrollment forms to your Employer

Revision 7/27/2009