PBA
Professional Benefit Administrators, Inc.

Flexible Benefit Plan Enrollment Form

Group Name: **Group Number:**

Last Name:	First:	MI:	PBA IID# **OR** SS# for new hire
Street Address	City	State	Zip
E-mail Address:			
Birthdate (*mm/dd/yyyy*)		Sex ☐M ☐F	
Marital Status: ☐ Single ☐ Married ☐ Divorced		Phone ( ) -	

Dependent Information Name	Date of Birth	Relation	Issue Debit Card? (must be 18 and older)
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

I am paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi Monthly	Hire Date *(mm/dd/yyyy)*

Salary Redirection Agreement And Election Of Benefits

As a Participant in The Flexible Benefit Plan, I understand that I may redirect a portion of my pay to provide benefits under the Plan. The amount of my redirection will be withheld from my paycheck each pay period. Therefore, my employer is hereby authorized to redirect my compensation in such an amount that is sufficient to provide the benefits I have elected below. I hereby elect the following benefits which are available under the Plan and designate the following amounts for each benefit I have selected.

	Annual Amount	**Amount Per Pay Period**
Medical Expense Reimbursement Account	$	$
Dependent Care Reimbursement Account (Recurring Claim forms can be found online)	$	$

Debit Card Agreement

According to the IRS guidance, Revenue Ruling 2003-43 upon every use of the Debit Card:

1) The card will only be used for eligible health care expenses. If ineligible expenses are purchased I will be required to reimburse the Plan.
2) The expense paid with the card has not been reimbursed under any other plan covering health benefits.
3) The card will only be used for point of service claims. I will not pay for balance due amounts on my card.
4) I will acquire and retain sufficient documentation and receipts for any expense paid with the card.
5) Reimbursement for health costs are processed only if they originate with certain vendors having health care related Merchant Codes.
6) Upon request, I will immediately submit the required documentation and receipts to Professional Benefit Administrators, Inc.
7) If I fail to produce the required documentation and receipts, I authorize my Employer to collect from me personally or withhold such funds from my payroll.
8) I understand that one debit card will be issued to the member. Cards are valid for up to 3 years. There will be a $10.00 replacement fee for lost or stolen cards. The fee will be deducted from my Medical Flex Spending Account balance.

If **Automatic Claim Rollover** is elected, my share of out-of-pocket expenses such as deductibles, office visits, co-pays and co-insurance will roll over to my Health FSA Account and I will automatically be reimbursed without the need to submit a claim.

Elect: ☐ Yes ☐ No

I have read and understand the items on the back of this form. The election made shall apply to the Plan Year from _____ through _____ (MM/DD/YYYY).

Participant's Signature Date Accepted by the Administrator

To be completed by Employer: Effective Date (mm/dd/yyyy)	First Ded. *(mm/dd/yyyy)*:

Note: There may be limits on the amounts which can be used for certain benefits. You should review your Summary Plan Description and ask your Administrator if you have any questions. Also, to complete the information on the front page, first determine your annual contribution for each benefit selected. Then, divide that amount by the number of pay periods remaining in the Plan Year and write that amount in the amount per pay period column.

With regard to my salary redirection agreement and my election of benefits, I understand that:

- I may **not** change elections during the Plan Year unless there is a change in my family status (e.g., marriage, divorce, death of my spouse or child, adoption or birth of my child, a change in the employment status of my spouse, or emergency medical leave).
- The Administrator is authorized to adjust the amount of my salary redirections and benefits if it is necessary to satisfy certain provisions of the Internal Revenue Code.
- My election of salary redirections and benefits will remain in effect only for the Plan Year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election not to participate in the Plan for that Plan Year.

Automatic Claim Rollover

- I understand that this option cannot be elected if I have other insurance due to complications with Coordination of Benefits and Federal law.
- I understand that I cannot use my PBA Visa Benefit Card if claims are eligible to be paid under the Group Health Plan, since certain out-of-pocket expenses will be reimbursed through Automatic Rollover. If duplicate payments are issued, I am responsible for reimbursing any overpayment.
- I understand I am fully responsible for the accuracy and authenticity of all information relating to all claims.
- I understand that I may be liable for payment of all related taxes including Federal, State or City income tax on amounts paid which relate to such expense if not eligible under IRS regulations.

I hereby apply for participation in the above referenced Plan. I acknowledge that I have received a Summary Plan Description and agree to abide by the rules and requirements under the Plan.

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek the payment of benefits under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

_____
Name

_____
Address

_____
Relationship

DECLINATION
The benefits of the plan have been thoroughly explained to me and **I DECLINE TO PARTICIPATE**.

_____ _____
Signature Date