

Office Use Only	
Date Processed:	/ /
Processed by:	Client #:

To be com	pleted by	emplovee	and given	to employer.

	KI ®			Processed by:	Client #:	
PrimeFlex—(877) 769-3	1539					
Pre-Tax Benefit Enrollment For				Entry (Effective) Date	۵۰	
o be completed by employee and given to en				Payroll Deduction St	•	
mployee Information (Please <u>print</u> clear	ly) 🗌 PLEASE CHE	CK HERE IF THIS IS AN A	DDRESS CHAI	NGE		
Name: (Last, First, Middle)			SSN:		Date of birth:	
Street:		City:		State:	Zip:	
Employer:					Work #:	
Email:					()	
Group Health Plan Name:					Hire Date:	
Please complete the following section to	indicate the type(s) No. of Pay	of benefits you want to	participate i	n and the amount y	ou would like to contri	bute.
Type Of Account (See Below)	Periods	EE Per Pay		ER Per Pay*	Annual Contrib	ution
	ļ	x			=	
		х			=	
		x				
		x				
				Tota		
Please see plan documents for information Types: Flexible Spending Account (FS			ccount (LPES			emium
Reimbursement Account (PRA), Mass Tr						
Please list those family members who are	e eligible dependen	t(s).				
Card* Spouse/Dependent		Relationship	Social	Security Number	Date of Birth	Sex
(Y/N)						(M/F
If Applicable						
I confirm that I am eligible to participat	e in the selected nl	ans I authorize the am	ount(s) ahove	to be deducted fro	ım my navcheck as ned	accary
understand that I can only use these ac	•					-
will only be used to pay for eligible ex	_					
year and may only be changed if I have	a qualifying event	. I understand that for	FSA, LPFSA, I	DCA, and PRA plans	s, any unused amounts	may b
forfeited if not used in the current plan	-		-	-		
that I must retain all receipts for purch						
expenses under my selected plans, I						-
dependents. This information will not by my employer. I confirm that to the b			_	-	illiates, or person auti	iorizea
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imployee Signature:				Date:	//	_
mnlover Initials						