PRIMEPAY®

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PrimeFlex—(877) 769-3539

Pre-Tax Benefit Enrollment Form

To be completed by employee and given to employer.

Entry (Effective) Date: _____

Payroll Deduction Start Date: _____

Employee Information (Please print clearly) ☐ **PLEASE CHECK HERE IF THIS IS AN ADDRESS CHANGE**

Name: (Last, First, Middle)		SSN:		Date of birth:
Street:	City:		State:	Zip:
Employer: GLENDALE COMMUNITY COLLEGE				Work #:
Email:				Mobile (Includes SMS Updates)
Group Health Plan Name:				Hire Date:

Please complete the following section to indicate the type(s) of benefits you want to participate in and the amount you would like to contribute.

Type Of Account (See Below)	No. of Pay Periods		EE Per Pay	ER Per Pay*		Annual Contribution
Flexible Spending Account	10	x		-N/A-	=	
Dependent Care Account	10	x		-N/A-	=	
		x		-N/A-	=	
		x		-N/A-	=	
				Total	=	$0.00

Please see plan documents for information on election maximums.

Types: Flexible Spending Account (FSA), Limited Purpose Flexible Spending Account (LPFSA), Dependent Care Account (DCA), Premium Reimbursement Account (PRA), Mass Transit Account (TRN), and Parking Account (PKG). Please consult your employer for more information.

Please list those family members who are eligible dependent(s).

Card* (Y/N)	Spouse/Dependent Name	Relationship	Social Security Number	Date of Birth	Sex (M/F)

***If Applicable**

I confirm that I am eligible to participate in the selected plans. I authorize the amount(s) above to be deducted from my paycheck as necessary. I understand that I can only use these accounts for eligible expenses as governed by the IRS and my plan documents and if I receive a debit card it will only be used to pay for eligible expenses. I understand that the elections for FSA, LPFSA, DCA, and PRA plans are irrevocable for the plan year and may only be changed if I have a qualifying event. I understand that for FSA, LPFSA, DCA, and PRA plans, any unused amounts may be forfeited if not used in the current plan year. I understand that the plan administrator may modify/cancel these plans at any time. I understand that I must retain all receipts for purchases and services rendered, and agree to provide them upon request. For the purpose of substantiating expenses under my selected plans, I hereby authorize the release of Protected Health Information (PHI) for myself and any qualifying dependents. This information will not be discussed with anyone other than my providers, employer, PrimeFlex/affiliates, or person authorized by my employer. I confirm that to the best of my knowledge all of the information provided is correct.

Employee Signature: _____ **Date:** ____/____/____

Employer Initials: _____