Pro-Flex
PRO-FLEX ADMINISTRATORS LLC

Health Reimbursement Account Enrollment Form

Step 1: Participant Information for CSEA Dental

*=Required Fields

*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:			
Dependent:			

Step 3: Authorization or Refusal

☐ **Participant Authorization includes Payroll deduction of $176 per calendar year for family coverage.**
I hereby enroll in the HRA benefit provided by my employer. 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.

☐ **Participant Refusal**
I do not want to participate. I understand that by refusing to participate, I will be unable to enroll this plan year unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit the change within 30 days of the event.

*Please select only one.

SIGNATURE OF PARTICIPANT_____ **DATE** _____

Step 4: Employer Authorization

_____
Effective Date

This is for Dental Benefit only
HRA Contribution Amount

SIGNATURE OF EMPLOYER_____ **DATE** _____