

**MEDFLEX  
MID-YEAR ENROLLMENT OR STATUS CHANGE**

MEDFLEX  
CO-1306a (Rev. 10/2017)

Office of the State Comptroller  
Healthcare Policy & Benefit Services Division

<b>EMPLOYEE INFORMATION</b>	Employee Name (last, first, middle initial)	Employee Number	Job Record Number
	Street Address	Date of Birth	Social Security Number (must be provided)
	City, State, Zip Code	Date of Hire	____ / ____ / ____
	Employee Personal Email	Office Telephone No.	Home Telephone No.
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
<b>ELIGIBILITY</b>	<p align="center">You CANNOT enroll in the MEDFLEX if you are:</p> <ul style="list-style-type: none"> <li>● On unpaid leave for any reason</li> <li>● Adjunct faculty or graduate assistant</li> <li>● Working or expected to work less than 0.5 full time equivalent (0.5 FTE)</li> <li>● Per Diem, sessional, durational, temporary or seasonal status</li> <li>● Former employees and rehired retirees</li> </ul>		
<b>ENROLLMENT INFORMATION</b>	(Please check applicable event) <input type="checkbox"/> New Hire <input type="checkbox"/> Return from leave <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Spouse's employment change <input type="checkbox"/> Death <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other Explain _____	Annual Election Amount    \$ _____ (Annual minimum is \$520 / Annual maximum is \$2,650)  I am paid on the following Payroll Cycle: <input type="checkbox"/> Bi-weekly (26) <input type="checkbox"/> Semi-Monthly (24) <input type="checkbox"/> Monthly (12) <input type="checkbox"/> Five Pay (5)	
	Are you planning to retire during 2018? <input type="checkbox"/> Yes <input type="checkbox"/> No    (If yes, insert month) _____ 2018		
	I elect to use the prepaid benefit card for this program <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>AUTHORIZATION</b>	<p>I certify that the above information is true and correct and that I will only use my MEDFLEX to pay for IRS-qualified expenses for myself and eligible dependents during the plan year. I understand that I cannot deduct expenses reimbursed by my MEDFLEX on my federal tax return. I will retain documentation for claim substantiation.</p> <p>I hereby authorize the State of Connecticut to reduce my gross salary, before federal, state and Social Security taxes are withheld by the total annual election amount indicated above and affirm my understanding that:</p> <ul style="list-style-type: none"> <li>● My election cannot be changed during the plan year, unless I experience a qualifying change in family status, as defined by the Internal Revenue Code Section 125. <i>Any election changes must be made within 31 days of the qualifying event.</i></li> <li>● MEDFLEX funds (in excess of \$500) that are not claimed for eligible plan year expenses by March 31, 2019, will be forfeited in accordance with Internal Revenue Code requirements.</li> </ul>		
Employee Signature		Date	

MAIL, EMAIL OR FAX COMPLETED FORM TO:

Progressive Benefit Solutions, LLC (PBS),  
14 Business Park Drive #8, Branford, CT 06405  
Phone 1-866-906-8023 or 203-985-1712  
FAX: 203-974-4898  
Email: Enrollment@pbscard.com