

**MEDFLEX
OPEN ENROLLMENT PLAN YEAR 2021**

MEDFLEX
CO-1306 (Rev. 9/2020)

Office of the State Comptroller
Healthcare Policy & Benefit Services Division

EMPLOYEE INFORMATION	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	
ELIGIBILITY	<p align="center">You CANNOT enroll in the MEDFLEX if you are:</p> <ul style="list-style-type: none"> - On unpaid leave for any reason - Adjunct faculty or graduate assistant - Working or expected to work less than 0.5 full time equivalent (0.5 FTE) - Per Diem, sessional, durational, temporary or seasonal status - Former employees and rehired retirees 		
ENROLLMENT INFORMATION	Annual Election Amount \$ _____ (Annual minimum is \$520 / Annual maximum is \$2,750) <input type="checkbox"/> If IRS maximum changes during open enrollment, to use that amount check this box.	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) <input type="checkbox"/> Special bi-weekly (26)	
	Are you planning to retire during 2021 ? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, insert month) _____		
	I elect to participate with the pre-paid debit card <input type="checkbox"/> Yes <input type="checkbox"/> No		
AUTHORIZATION	<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 my 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"> 1 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 and consistent with the change in status.</i> 1 MEDFLEX funds in excess of \$550 that are not claimed for eligible plan year expenses by March 31, 2022, will be forfeited in accordance with Internal Revenue Code requirements. 		
Employee Signature		Date	

MAIL, E-MAIL 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