

# BENEFLEX, INC. MEDICAL FLEXIBLE SPENDING ACCOUNT APPLICATION

624 Grassmere Park Drive, Suite 15  
Nashville, TN 37211  
Fax (615) 831-9910 - (800) 449-7501

YOUR E-MAIL: \_\_\_\_\_

Plan Year \_\_\_\_\_ through \_\_\_\_\_

Employer \_\_\_\_\_ Telephone \_\_\_\_\_

Employer Address \_\_\_\_\_

(City)

(State)

(Zip)

Employee \_\_\_\_\_  
(First Name) (MI) (Last Name)

Social Security Number    —   —

Home Telephone Number:    —    —

Address: \_\_\_\_\_

(City)

(State)

(Zip)

Name of Bank \_\_\_\_\_ Checking  Savings

Routing Number          ( First 9 numbers on left bottom of check)

Banking Account #

I Elect to Participate to participate and designate the following amount for my MedFSA:

WEEKLY \$ \_\_\_\_\_

BI-WEEKLY \$ \_\_\_\_\_

SEMI-MONTHLY \$ \_\_\_\_\_

MONTHLY \$ \_\_\_\_\_

TOTALING A YEARLY DEDUCTION OF \$ \_\_\_\_\_

As an eligible employee, I understand a copy of a Summary Plan Description (SPD) and plan document is available at my place of work. I understand the benefits and my rights and obligations under the plan.

I understand that only eligible medical expenses for myself, my spouse and my dependents, as outlined in the SPD and IRS Pub. 502, and which are not reimbursed under any other medical plan available to me, qualify for reimbursement under this Plan. I agree to contact the Plan Administrator or my employer for clarification if I have any reason to believe that I have received a benefit for any expenses which do not qualify. I understand this redirection may have minimal effect on my Social Security Benefits. I understand that amounts redirected into this account may not be used in any other benefit plan, refunded or carried over to the following year. I understand that, except for certain family situations as defined by the SPD, my participation in this Plan is for the entire Plan Year. Prior to the beginning of each Plan Year, I will be given an opportunity to change the amount of my election or revoke my participation if I do not submit a new election, the prior year's election will remain in effect for the new Plan Year. I understand that in the event of my death, any benefit due me will be paid to my estate.

Signed \_\_\_\_\_ Date \_\_\_\_\_