Flex Benefit Plan
Enrollment/ Change Form

Health, Wellness & Benefits Office
2714 Union Avenue Ext. 5th Floor Room 100
Memphis, Tennessee 38112
Phone: (901) 636-6800
Fax: (901) 636-8486

Change Type: Date of Event _____/_____/____

o Address/Name change
o New Hire
o Termination (must complete COBRA form*)
o Change in Status _____
o Unpaid Leave of Absence
o Return from Leave of Absence

*For out-of-Pocket Medical Expense account participants

Please call Cigna Healthcare if you have any questions
1-800- CIGNA24 or 1-800-244-6224

1 Employee Information

Social Security Number - -	Email Address
Employee Name (Last, First, Middle Initial)	
Street Address	
City, State, Zip Code	

Plan Year: From ____/_____/_____

To _____/____/_____

Effective Date _____/_____/_____

2 Flex Benefit Election

☐ I hereby elect to participate in the Flex Benefit Plan offered by my Employer, thereby paying my expenses with before-tax dollars. I hereby authorize my Employer to reduce my income subject to taxes in the total amount stated below for the above Plan Year. If my group insurance requires a change in my contribution during the Plan Year I authorize my Employer to make the contribution adjustments.

I. Dependent Day Care Expenses **$** _____ - _____ = **$**_____
Election Amount # of Pay Periods Amount Per Pay Period

II. Out-of-Pocket Expenses **$** _____ - _____= **$**_____
(Expenses for Medical, Dental, Vision, etc.) Election Amount # of Pay Periods Amount Per Pay Period

Do you or any of your family members participate in a Health Savings Account (HSA)? Yes No
(If yes, an out-of-pocket medical expense FSA is not available.)

☐ I hereby elect NOT to participate in the Flex Benefit Plan offered by my Employer, thereby paying my expenses with after-tax dollars. I also understand that I will have an opportunity to make a new election, if I so desire, prior to the beginning of each subsequent Plan year, in accordance with the procedures described in the Plan Document.

3 Signature and Acknowledgement - Please read before signing

This agreement will remain in effect for the Plan year unless changed for reasons stated in the terms and conditions of the Plan. By affixing my signature below, I certify that I have examined this agreement and understand and agree to comply with the terms and conditions of the Plan. If this is a change in status, I certify that this change is consistent with the qualifying event. I agree to hold Cigna Healthcare and my Employer harmless from any liability to my participation in this plan.

_____ _____
SIGNATURE **DATE**

_____ _____
NOTARIZED SIGNATURE OR HEALTH, WELLNESS & BENEFITS REPRESENTATIVE **DATE**