FBMC
BENEFITS MANAGEMENT
Mail Slot #37, P.O. Box 1878, Tallahassee FL 32302-1878
Fax 850-514-5803 • Phone 800-872-0345

Cash Match Agreement

Commonwealth of Virginia Department of Accounts

Please use this form to direct your Virginia Cash Match employer contribution to the participating provider company of your choice. Upon completion, return this form to your Payroll Administrator.

Date: _____

New Enrollment Cash Match

❑ I would like to start my Cash Match

Provider Company: _____

Effective with Check Date: _____

Change of Provider

❑ I would like to change my Cash Match

Old Provider Company: _____

New Provider Company: _____

Participant Information

Agency #: _____ Agency Name: _____

First Name		MI	Last Name	
Social Security #	Employee ID#		Home Phone #	Work Phone #
Home Address			Date of Birth	Date of Hire
City			State	Zip

_____ _____

Participant Signature Date

_____ _____

Employer Representative Date

_____

Title