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