Innovative Business Consultants

Flex Enrollment Form

Employer	Division		Effective Date	
Employee Last Name	First Name	Middle Initial	Date of Birth	☐ Male ☐ Female
Street Address	City		State	Zip
Social Security Number	Email Address			
Date of Hire	☐ Married ☐ Widowed ☐ Single ☐ Divorced		Cell Phone # ( )	
Spouse Name		Gender ☐ Male ☐ Female	Date of Birth	
Dependent Name		Gender ☐ Male ☐ Female	Date of Birth	
Dependent Name		Gender ☐ Male ☐ Female	Date of Birth	
Dependent Name		Gender ☐ Male ☐ Female	Date of Birth	

Health Care Flexible Spending Account

I authorize the following amount to be deducted from my paycheck and placed in my Health Care Flexible Spending account:

$ _____/Year which is $ _____/Paycheck

☐ I do not wish to participate in the Health Care Flexible Spending Account.

Dependent Care Flexible Spending Account

I authorize the following amount to be deducted from my paycheck and placed in my Dependent Care Flexible Spending account:

$ _____/Year which is $ _____/Paycheck

☐ I do not wish to participate in the Dependent Care Flexible Spending Account.

I understand that the contributions to my reimbursement account(s) can be reimbursed to me for eligible expenses incurred with the plan year. I understand that if I do not use the funds in my reimbursement account(s) during the plan year, those funds may be forfeited.

Employee Signature: _____ Date: _____

This agreement will continue until: 1) I terminate employment 2) I have a qualifying status change 3) the end of the current plan year, or 4) my employer terminates, suspends, or modifies this plan.

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