



Innovative Business Consultants

Flex Enrollment Form

Employer		Division		Effective Date	
Employee Last Name	First Name		Middle Initial	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City		State	Zip
Social Security Number		Employee Id/# (if applicable)			
Email Address					
Date of Hire	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced		Cell Phone # ()		
Spouse Name			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Dependent Name			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Dependent Name			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Dependent Name			Gender <input type="checkbox"/> Male <input type="checkbox"/> 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.