Contact Us Today!
www.myflexinfo.com

Additions and Terminations Form

Please keep Flex informed of any changes immediately. Please allow 5 to 7 business days for processing. Flex will not be held responsible for over-payments.

Employer Name: ______________________

Employee Name: ______________ SSN: ____________ Date of Birth: ________

Status: ☐ *Addition* Effective Date: ____________ ☐ *Termination of Employment* Effective Date: ____________

(If benefit termination date is other than employment termination date, please indicate here) *Termination of Benefit* Effective Date: ____________

Address: ______________ City: ____________ State: ______ Zip Code: ________

Phone Number: ______________ Email Address: ______________

Plan (check all that apply): ☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ FSA ☐ FSA Limited ☐ Dependent Care

Pay Period Deduction: $______ $______ $______ $______ $______ $______ $______

Pay Period Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly

First / Last Payroll Deduction (date) ____________ Date of Hire (additions only): ____________

Employee Name: ______________ SSN: ____________ Date of Birth: ________

Status: ☐ *Addition* Effective Date: ____________ ☐ *Termination of Employment* Effective Date: ____________

(If benefit termination date is other than employment termination date, please indicate here) *Termination of Benefit* Effective Date: ____________

Address: ______________ City: ____________ State: ______ Zip Code: ________

Phone Number: ______________ Email Address: ______________

Plan (check all that apply): ☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ FSA ☐ FSA Limited ☐ Dependent Care

Pay Period Deduction: $______ $______ $______ $______ $______ $______ $______

Pay Period Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly

First / Last Payroll Deduction (date) ____________ Date of Hire (additions only): ____________

Employee Name: ______________ SSN: ____________ Date of Birth: ________

Status: ☐ *Addition* Effective Date: ____________ ☐ *Termination of Employment* Effective Date: ____________

(If benefit termination date is other than employment termination date, please indicate here) *Termination of Benefit* Effective Date: ____________

Address: ______________ City: ____________ State: ______ Zip Code: ________

Phone Number: ______________ Email Address: ______________

Plan (check all that apply): ☐ Medical ☐ Dental ☐ Life ☐ Vision ☐ FSA ☐ FSA Limited ☐ Dependent Care

Pay Period Deduction: $______ $______ $______ $______ $______ $______ $______

Pay Period Frequency: ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly

First / Last Payroll Deduction (date) ____________ Date of Hire (additions only): ____________

Invoices are issued by the 10th of each month and the billing period is one month in advance. Additions and terminations received by the 1st of the month will be reflected on the following month's invoice. (i.e. Changes submitted by October 1st will be reflected on the November invoice.)

Plan Administrator Signature: ____________________ Date: ____________

Please send all completed forms and documentation to Flexible Benefit Service Corporation.

FLEX **Flexible Benefit Service Corporation** 8700 W. Bryn Mawr Avenue, Suite 1010S, Chicago, IL 60631

p: 866-472-0882 // f: 847-440-9100 // dcinfo@flexiblebenefit.com

© Flexible Benefit Service Corporation 2010