Additions Form

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www.myflexinfo.com

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 #1 Name: ______________ SSN: ______________ Date of Birth: ______________

Status: ☐ *Addition* Effective Date: ______________ ☐ *COBRA Reinstatement* Effective Date: ______________

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

Phone Number: ______________ Email Address: ______________

HRA Plan (check all that apply)*: ☐ Employee Only ☐ Employee + 1 ☐ Family ☐ Other

Date of Hire (additions only): ______________

Employee #2 Name: ______________ SSN: ______________ Date of Birth: ______________

Status: ☐ *Addition* Effective Date: ______________ ☐ *COBRA Reinstatement* Effective Date: ______________

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

Phone Number: ______________ Email Address: ______________

HRA Plan (check all that apply)*: ☐ Employee Only ☐ Employee + 1 ☐ Family ☐ Other

Date of Hire (additions only): ______________

*MSP Reporting Requirements: Please provide Employee Spouse and all Dependent information if participant/spouse is 45 years of older and/or on Medicare. Please complete MSP reporting section below.

MSP Reporting Section

In this section of the form, please fill in Spouse/Dependent information required for MSP Reporting.

Employee #1 Name: ______________

Spouse Name: ______________ Date of Birth: ______________

SSN: ______________ Gender: ☐ Female ☐ Male

Dependent #1 Name: ______________ Date of Birth: ______________

SSN: ______________ Gender: ☐ Female ☐ Male

Dependent #2 Name: ______________ Date of Birth: ______________

SSN: ______________ Gender: ☐ Female ☐ Male

Employee #2 Name: ______________

Spouse Name: ______________ Date of Birth: ______________

SSN: ______________ Gender: ☐ Female ☐ Male

Dependent #1 Name: ______________ Date of Birth: ______________

SSN: ______________ Gender: ☐ Female ☐ Male

Dependent #2 Name: ______________ Date of Birth: ______________

SSN: ______________ Gender: ☐ Female ☐ Male

If additional space is needed for Dependent information, please use another FlexHRA Additions Form.

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.

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