



# Dependent Form

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Date: \_\_\_\_\_  
Fax- # of Pages: \_\_\_\_\_

Please follow the steps below to thoroughly and accurately complete this form.

### Step 1: Personal Information

Company Name: \_\_\_\_\_  
Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

### Step 2: Dependent Information

Dependent Name	Social Security # (SSN)*	Date of Birth	Gender	Relationship to Employee
_____	_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	_____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____

\*Social Security Number is required.

### Step 3: Employee Signature

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please keep Flex informed of any changes to your Dependent information. Upon completion of this form, please *return to your Plan Administrator* for submission to Flex.

**Plan Administrator:** Please return completed form to Flex by mail or fax. If employee is an addition to the HRA Plan, please return this form along with a completed FlexHRA Change in Status Form, to the address or fax number listed below.