IPG Flex Plan
Enrollment Form

For the plan year ___________

Company Name __________________________

Please Print

Name _______________________________________ **Social Security #** ________________________________

Mailing Address: ____ Email Address: ___________________

Please mark your choice below:

____ **Flexible Spending Accounts**

____ **Medical Reimbursement** **Annual Election $** ____________ **Per Paycheck $** ______________

____ **Dependent Care** **Annual Election $** ____________ **Per Paycheck $** ______________

____ **I do not wish to participate.** I do not elect to enroll in either of the salary reduction programs.

I understand:

- I cannot change this election during the plan year unless I have a change in status as defined by the plan.
- Any benefit left in my FSAs after the end-of-year grace period will be forfeited.
- My Social Security benefits may be reduced by this election of salary reduction.
- This election replaces any previous elections and will terminate on the earlier of:
  - the end of the plan year.
  - the date I am no longer paid compensation at least equal to my total salary reduction.
  - termination of the plan.
- My employer may reduce or cancel this election if necessary to comply with non-discrimination regulations of the Internal Revenue Code.

Signature _____________________________________ Date ____

To Be Completed by Employer

Accepted by ___________________________________ Date ____

Please submit one to IPG Employee Benefits, another should be kept by the employer, one to be retained by the employee.