



EMPLOYER REQUEST FOR SERVICE FORM (Please check only the boxes that apply.)

GENERAL INFORMATION

Company Name: _____
Plan Administrator Name: _____ Telephone: (____) ____ - _____
Company Address: _____
City: _____ State: _____ Zip: _____
Email: _____

TO ENSURE CONFIDENTIALITY, AmeriFlex employees are not permitted to discuss information with anyone who is not listed as a current client contact. To authorize information access by multiple representatives from within your company, please list each additional representative on the *Add Authorized Contact* section of this form. (Brokers and/or enrollment representatives may be selected as authorized contacts.)
The AmeriFlex Request for Service Form will not be processed unless it has been completed by the current client contact and/or broker listed on file with AmeriFlex.

COMPANY NAME/ADDRESS CHANGE

New Name: _____ New phone: (____) ____ - _____
New Address: _____
City: _____ State: _____ Zip: _____

ADD AUTHORIZED CONTACT

Name: _____ Title: _____
Company: _____
Telephone: (____) ____ - _____ Email _____

REMOVE AUTHORIZED CONTACT

Name: _____ Title: _____
Company: _____
Telephone: (____) ____ - _____ Email _____

EMPLOYEE TERMINATION

Employee Name: _____ SSN: _____
Date of Termination: _____ Date of Last Payroll Deduction: _____

Employee Termination/Claims Procedure: AmeriFlex will deactivate the terminated employee's AmeriFlex Convenience Card® on the date notified of the termination. Any eligible expenses incurred, and not yet submitted for reimbursement, prior to or on the date of termination, must be filed using a manual claim form and must be received by AmeriFlex within 90 days of the termination date.

Date _____ Signature _____