Flexible Spending Account (FSA)
Health Care and Dependent Care Enrollment

Employee Information

Social Security Number	Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)

Date of Hire (MM/DD/YYYY)	Home Telephone Number	Business Telephone Number
	( )	( )

Street Address City State Zip Code

Employer Information

Employer Name

Contributions

Complete the following section to elect the type(s) of flexible spending account plan(s) you wish to participate in and designate the per pay period contribution amounts. W=Weekly; B=Biweekly; S=Semi-monthly; M=Monthly

I wish to participate in the following flexible spending account plans:

	Contribution Per Pay Period	**Pay Cycle**
☐ Health Care FSA	$ _____	_____
☐ Dependent Care FSA	$ _____	_____

I authorize my employer to deduct the premiums selected below from my paycheck on a pretax basis:

☐ Health Insurance Premium	$ _____	_____
☐ Dental Insurance Premium	$ _____	_____
☐ Life Insurance Premium	$ _____	_____

Authorization - Please read the following statements and then sign and date this form.

I authorize the reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that the amounts deducted from my pay and not used for eligible health care and/or dependent care expenses incurred the same plan year **will be forfeited** in accordance with IRS regulations.

I also understand that this authorization is irrevocable until the next election period unless I have a change in family status.

Signature _____ Date _____