Healthcare and Dependent Care Flexible Spending Account (FSA): Employee Enrollment and Salary Reduction Agreement

Employee information

Name _____ **Last four digits of SSN** _____

Address _____

City _____ **State** _____ **ZIP code** _____

Daytime phone (_____) _____ **Email** _____

Reason for election (check one):

☐ Annual enrollment election ☐ New employee enrollment ☐ Qualifying life event

Effective date: _____(completed by employer)

Election and salary reduction for flexible spending account(s)

Healthcare flexible spending account

I authorize a salary reduction of $_____per year (deducted in generally equal amounts per pay) to my healthcare FSA. Visit pensions.org/irslimits for annual maximum contribution amounts.

Dependent care flexible spending account

I authorize a salary reduction of $ per year (deducted in generally equal amounts per pay) to my dependent care FSA. Visit pensions.org/irslimits for annual maximum contribution amounts.

Acknowledgment, acceptance, and signature

I understand and accept the following terms and conditions:

- This authorization will be in effect for the plan year specified by the effective date. Elections for FSAs must be made on an annual basis.
- By completing and signing this form, I am authorizing my employer to withhold wages from my salary to be contributed to healthcare and/or dependent care FSAs.
- I understand that these enrollment elections and my authorization to withhold my FSA contributions cannot be changed except during Annual Enrollment or upon a qualifying life event.
- I am responsible for initiating any change in my elections due to a qualifying life event, as described under the plan, within 60 days of such event. Any contributions or changed contributions must be made after the changed contribution is submitted; retroactive changes are not permitted.
- Any contributions that are not used for reimbursement of allowable expenses during the benefits period (as defined in the plan) are forfeited at the end of that period.
- I affirm that neither I nor my spouse contribute, or will contribute, to a health savings account (HSA) while enrolled in a healthcare FSA.

Employee's signature (*required*) _____ **Date** _____