FSA Election Form

Date: _____
Fax- # of Pages: _____

Personal Information (*Required)

*Company Name: _____ *Effective Date of Election: ___/___/___

*Employee Name: _____ *Gender: _____

Date of Hire: ___/___/___ *SSN: _____ *Date of Birth: ___/___/___

*Address: _____ *City: _____ *State: _____ *Zip Code: _____

Phone Number: _____ Fax Number: _____ *Email Address: _____

Enter Annual Election

FSA Elections	Annual Election Amount	Pay Period Frequency (W, B, S or M*)	First Payroll Date Affected
Health Care FSA**	$ _____	_____	_____
Limited Purpose FSA**	$ _____	_____	_____
Dependent Care FSA	$ _____	_____	_____

Remember, when your needs change, FlexFSA does too! You can change your premium elections any time you have a qualifying event that would change the status and/or premium amount of your employee insurance (i.e. marriage, divorce, birth or death of a child, death of a spouse, adoption or change of employment by spouse).

***Pay Period Frequency: W = Weekly; B = Biweekly; S = Semi-monthly; M = Monthly**

****If you have an HSA, you are only eligible to participate in a Limited Purpose FSA if offered by your employer**

Acknowledgement and Signature

☐ I acknowledge that I am authorizing the company to deduct equal amounts from my paychecks to collect the designated pre-tax column above. I recognize that these selections constitute a deliberate binding decision on my part that may not be changed until the enrollment period for the next plan year or if I experience a change in status

Employee Signature: _____ Date: _____

OR

☐ I elect **NOT** to participate in any portion of the FlexFSA plan. (i.e FSA, Dependent Care, Limited Purpose).

Employee Signature: _____ Date: _____

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