# FSA Election Form

Employer Name: _____

Employee Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ◯ Single ◯ Married

Employer Group #: _____

SS#: _____

Date of Birth: _____/_____/_____

Date of Hire: _____/_____/_____

Gender: ◯ Male ◯ Female

Effective Date: _____/_____/_____

## Health Care FSA

You may choose to contribute pre-tax dollars that can be used to pay certain health care expenses incurred during the plan year. You should only contribute an amount that you will be certain to use for health care expenses because current tax law does not allow you to receive a refund or to use the balance for another purpose.

☐ I elect not to participate at this time. I realize that should I desire to enroll in this plan in the future, I must wait until the next annual enrollment or special enrollment event.

☐ I elect to reduce my salary to fund my health care FSA with pre-tax dollars. $ _____ and $ _____
PER PAY ANNUAL

**Note:** As of 2014, employer contributions into the health FSA must be under $500 or not more than a 100% match of employee contributions.

Employer Contribution: $ _____
ANNUAL

## Dependent Care FSA

You may choose to contribute pre-tax dollars that can be used to pay certain dependent care expenses incurred during the plan year. You should only contribute an amount that you will be certain to use for dependent care because current tax law does not allow you to receive a refund or to use the balance for another purpose.

☐ I elect not to participate at this time. I realize that should I desire to enroll in this plan in the future, I must wait until the next annual enrollment or special enrollment event.

☐ I elect to reduce my salary to fund my dependent care FSA with pre-tax dollars. $ _____ and $ _____
PER PAY ANNUAL

**Note:** As of 2014, employer contributions into the health FSA must be under $500 or not more than a 100% match of employee contributions.

Employer Contribution: $ _____
ANNUAL

I hereby apply for the options listed above. I understand that this election is binding and cannot be changed except under limited circumstances established by the plan. I also understand that my rights to any unused portion of the amounts allocated to my account(s) may revert to my employer at the end of the plan year, or earlier if I terminate employment.

I authorize my employer to reduce my salary by the amounts indicated above.

Employee's Signature: _____ Date: _____

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