

HEALTHCARE & DEPENDENT CARE FSA

Payroll Authorization & Change Form

Use this form to establish, change, or terminate payroll withholdings for your Flexible Spending Accounts (FSA). Please ensure all sections are completed and submitted to the Payroll/HR Department for processing.

EMPLOYER INFORMATION

Company Name: _____ Division/Branch: _____

EMPLOYEE INFORMATION

Employee Name: _____ Employee ID: _____
Social Security No: _____ Department: _____
Effective Date: _____ Pay Frequency: _____

ELECTION & PAYROLL DEDUCTION DETAILS

Account Type	Annual Election (\$)	Pay Periods Per Year	Per Pay Period Deduction (\$)
Healthcare FSA Medical, Dental, Vision expenses			
Dependent Care FSA Daycare, Preschool, Elder care expenses			

AUTHORIZATION AND AGREEMENT

I hereby authorize my employer to reduce my gross salary by the amounts indicated above for the purpose of funding my Flexible Spending Account(s). I understand that these pre-tax designations are binding and cannot be changed during the plan year unless I experience a qualifying life event. Any unused funds remaining in my accounts at the end of the plan year (or grace period, if applicable) may be forfeited in accordance with IRS regulations and plan rules.

Employee Signature

Date

PAYROLL / HR DEPARTMENT USE ONLY

Date Received: _____ Processed By: _____
First Payroll Date: _____ Signature: _____