

FLEXIBLE SPENDING ACCOUNT (FSA)

Payroll Deduction Authorization Form

EMPLOYER INFORMATION

Employer Name

Plan Year

EMPLOYEE INFORMATION

Employee Name (Last, First, Middle Initial)

Social Security Number / Employee ID

Street Address

Phone Number

City, State, Zip

Email Address

Payroll Frequency

- ☐ Weekly
☐ Bi-Weekly
☐ Semi-Monthly
☐ Monthly

FSA ELECTION & DEDUCTION AUTHORIZATION

Specify the total annual contribution amount for each account type. The payroll department will calculate the per-pay-period deduction based on your payroll frequency.

Account Type	Annual Election Amount	Number of Pay Periods	Deduction Per Pay Period
Health Care FSA For eligible medical, dental, and vision expenses.	\$ _____	_____	\$ _____
Dependent Care FSA For eligible daycare, nursery school, and elder care.	\$ _____	_____	\$ _____

AUTHORIZATION AGREEMENT

I hereby authorize my employer to reduce my gross salary before taxes are calculated by the amounts indicated above for the designated plan year. I understand that:

1. This election cannot be changed or revoked during the plan year unless I experience a qualifying life event (e.g., marriage, divorce, birth, death, or change in employment status).
2. 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 terms.
3. The deductions authorized above will be allocated to my Flexible Spending Account(s) in equal installments based on my pay frequency.

Employee Signature

Date

Authorized Employer / HR Representative Signature

Date Received
