

FLEXIBLE SPENDING ACCOUNT (FSA)

Salary Reduction Agreement

Employer Name: _____

Employee Name: _____ Employee ID/SSN: _____

Plan Year: _____ Effective Date: _____

BENEFIT ELECTIONS

I hereby elect to participate in the Employer's Flexible Spending Account Plan for the Plan Year specified above. I authorize the employer to redirect my salary on a pre-tax basis as indicated below.

Account Type	Total Annual Election	Per Pay Period Deduction
Health Care FSA For eligible medical, dental, and vision expenses.	\$ _____	\$ _____
Dependent Care FSA For eligible daycare and eldercare expenses.	\$ _____	\$ _____
Limited Purpose FSA For vision and dental only (HDP/HSA compatible).	\$ _____	\$ _____

AUTHORIZATION & AGREEMENT

I understand and agree that:

1. My salary will be reduced by the amounts indicated above, in equal installments over the remaining pay periods of the Plan Year.
2. This agreement is binding and cannot be revoked or changed during the Plan Year unless I experience a qualifying life event (e.g., marriage, divorce, birth of a child, change in employment status) as defined by the IRS.
3. Any unused funds remaining in my account(s) at the end of the Plan Year (or after any applicable grace period/carryover period) will be forfeited in accordance with IRS regulations and plan rules.
4. The redirection of my salary under this agreement may affect my Social Security benefits, as those benefits are calculated based on my taxable earnings.
5. I am responsible for retaining all receipts and documentation for expenses submitted for reimbursement to substantiate that they are eligible expenses under Section 125 of the Internal Revenue Code.

Employee Signature: _____ Date: _____

HR / Employer
Authorized Signature: _____ Date: _____