

Flexible Spending Account (FSA) Election & Withholding Agreement

Plan Year:

EMPLOYEE INFORMATION

Employee Name

Employee ID

Social Security Number (Last 4 digits)

Department

Date of Hire

PAYROLL FREQUENCY

- ☐ Weekly (52)
- ☐ Bi-Weekly (26)
- ☐ Semi-Monthly (24)
- ☐ Monthly (12)

FSA ELECTION & SALARY REDUCTION AGREEMENT

Specify the dollar amount you elect to contribute for the plan year. The annual election will be divided by the number of pay periods remaining in the plan year to determine your pre-tax per-pay-period withholding.

Account Type	Annual Election Amount (\$)	Per Pay Period Amount (\$)
Health Care FSA For eligible medical, dental, and vision expenses.		
Dependent Care FSA For eligible child and adult daycare expenses.		

AUTHORIZATION & AGREEMENT

I hereby authorize my employer to reduce my salary before taxes on a pro-rata basis by the annual amounts indicated above for the specified plan year. I understand and agree that:

- This election cannot be changed or revoked during the plan year unless I experience a qualifying life event.
- Any unused funds remaining in my account at the end of the plan year (or grace period, if applicable) may be forfeited in accordance with IRS regulations and plan rules.
- This agreement will automatically terminate if my employment terminates, and my participation in the plan will be subject to the terms of the Summary Plan Description.

Employee Signature

Date

FOR HR & PAYROLL USE ONLY

Date Received

Effective Date

First Payroll Date

Processed By (Signature)

Date Processed

Please return the completed and signed form to the Human Resources/Payroll Department.