

PRE-TAX FSA PAYROLL WITHHOLDING AUTHORIZATION

Flexible Spending Account (FSA) Enrollment / Change Form

EMPLOYER INFORMATION

Company Name: _____ Plan Year: _____

EMPLOYEE INFORMATION

Employee Name: _____ Employee ID: _____
Department: _____ Email Address: _____
Pay Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

FSA ELECTION DETAILS

Specify your annual contribution limits for the current plan year. The payroll department will calculate and deduct the per pay period amount based on your selection and remaining pay periods.

FSA Account Type	Total Annual Election (\$)	Number of Pay Periods	Per Pay Period Deduction (\$)
Health Care FSA For eligible medical, dental, and vision expenses	\$		\$
Dependent Care FSA For eligible day care and elder care expenses	\$		\$

AUTHORIZATION & ACKNOWLEDGEMENT

I hereby authorize my employer to reduce my gross salary on a pre-tax basis by the total annual election amount(s) specified above, divided equally among the remaining pay periods in the plan year. I understand that:

- This election cannot be changed or revoked during the plan year unless I experience a qualifying life event (e.g., marriage, divorce, birth of a child) as defined by the IRS.
- Any unused funds remaining in my account at the end of the plan year (or grace period, if applicable) may be forfeited under the IRS "use-it-or-lose-it" rule.
- The pre-tax deductions reduce my taxable income, which may slightly affect my future Social Security benefits.
- These contributions must be used exclusively for qualifying medical or dependent care expenses incurred during the active coverage period.

Employee Signature _____ Date _____

FOR HR / PAYROLL DEPARTMENT USE ONLY

Date Received: _____ Effective Date: _____

HR/ Payroll Representative Authorized Signature _____ Date _____