

**Flexible spending account (FSA)  
employee enrollment form**



Please return this form to your HR department.

<b>Employer information</b>	
Employer name	

<b>Account holder information</b>			
First name	M.I.	Last name	
SSN	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)	
Email address		Home phone	
Physical street address	City	State	ZIP
Mailing address (if different)	City	State	ZIP

<b>FSA coverage</b>	
Coverage effective date	

<b>Annual elections</b>			
	Contribution per pay period	Number of pay periods remaining in plan year	Your annual election amount
<b>Flexible spending account</b>	\$	X	= \$
<b>Limited purpose flexible spending account (LPFSA)</b>	\$	X	= \$
<b>Dependent care flexible spending account (DCRA)</b>	\$	X	= \$
Contribution per pay period x number of pay periods = your annual election amount			

<b>Signature</b> <input type="checkbox"/> I decline to participate in the FSA plan.		
Print name	Signature	Date