

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



Please return this form to your HR department.

Employer information	
Employer name	

Account holder information			
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

FSA coverage	
Coverage effective date	

Annual elections			
	Contribution per pay period	Number of pay periods remaining in plan year	Your annual election amount
Flexible spending account	\$ 0.00	X 0	= \$ 0.00
Limited purpose flexible spending account (LPFSA)	\$ 0.00	X 0	= \$ 0.00
Dependent care flexible spending account (DCRA)	\$ 0.00	X 0	= \$ 0.00
Contribution per pay period x number of pay periods = your annual election amount			

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