



EMPLOYER

Name _____ Employer Tax ID # _____ FSA Plan Year _____

Payrolls in Plan Year _____ Date of first contribution ____/____/____ Weekly Bi-Weekly Semi-Monthly Monthly

EMPLOYER ONLY FSA FUNDING (Amount employer will contribute to the FSA - not to exceed IRS maximum.)
Annual Medical FSA benefit per employee \$ _____ per employee/spouse/children/family \$ _____

EMPLOYER FSA MAXIMUM (Maximum amount employer will allow - not to exceed IRS maximum.)
Medical FSA Plan \$ _____ Maximum employer allowed Dependent Care FSA (Non Medical) \$ _____ Maximum employer allowed

EMPLOYER TRANSPORTATION MAXIMUM - 132(f) Plan (Maximum amount employer will allow - not to exceed IRS maximum.)
Transit \$ _____ Maximum employer allowed Parking \$ _____ Maximum employer allowed

EMPLOYEE

Last Name _____ First _____ MI _____ Date of Birth ____/____/____

Address _____ City _____ State _____ Zip _____ New Address? Y N

Employee SS# _____ Phone _____ Marital Status _____ Gender M F

Date of Hire _____ Eligibility Date if New Hire/Rehire _____ E-mail _____

EMPLOYEE FSA FUNDING (Amount employee elects to contribute - up to employer maximum.)
Medical FSA Plan \$ _____ Annual election I elect to waive coverage
Dependent Care FSA (Non Medical) \$ _____ Annual election (\$5,000 max if married filing jointly, \$2,500 max if married filing separately) I elect to waive coverage

EMPLOYEE FUNDING TRANSPORTATION - 132(f) Plan (Amount employee elects to contribute - up to employer maximum.)
Transit \$ _____ Annual election I elect to waive coverage
Parking \$ _____ Annual election I elect to waive coverage

List FSA or HRA dependents below: (If additional space is needed, please use another sheet.)

Table with 8 columns: Social Security #, Last Name, First Name, MI, Relationship, Date of Birth, Gender (M/F), Extra Card. Includes checkboxes for gender and extra card.

FSA Plan Agreement I understand and agree that: I may elect coverage under any or all of the above components. I cannot change or revoke this FSA agreement during the plan year, unless the plan administrator determines that I will have incurred a qualifying change in status under IRS Code Section 125.

Debit Card Holder Agreement I understand and agree that: My employer and/or I have the right to suspend or terminate my card. Any violation of my cardholder agreement will result in suspension or termination of my card.

I certify that I have read, understand and agree to the terms above. Number of extra cards @ \$5.00 per card: _____ Additional debit card monthly fee \$2.50

Employee's signature: _____ Date: _____