



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/spouse/children/family.

EMPLOYER FSA MAXIMUM (Maximum amount employer will allow - not to exceed IRS maximum of \$3,300.)

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 of \$325.)

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, Extra Card. Includes checkboxes for M/F 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: \_\_\_\_\_