# FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

## 1. PARTICIPANT INFORMATION

| Name (please print): | Social Security/EEID#: | |
|---|---|---|
| Address: | Date of Birth (MM/DD/YYYY): | Gender: |
| City: | State: | ZIP: |
| Cell Phone Number: | Home Phone Number: | |

Marital Status: ☐ Single ☐ Married ☐ Married Filing Separately

## 2. HEALTHCARE FLEXIBLE SPENDING ACCOUNT

*Please check (✓) one box*

The Healthcare FSA allows you to set aside pre-tax dollars via payroll deductions to pay for qualified healthcare expenses for you and your dependents.

☐ **Yes,** I want to participate.

$ ______________________ ÷ __________________________ = $ ________________________________

Plan Year Contribution $3,200 | # Pay Periods in the Plan Year | Per Pay Pre-Tax Contribution

☐ **No,** I do not want to participate

## 3. COMMUTER FLEXIBLE SPENDING ACCOUNT

*Please check (✓) one box*

The Commuter FSA allows you to set aside pre-tax dollars via payroll to pay for expenses related to parking and mass transit, such as train, bus fares, or ferry rides.

☐ **Yes,** I want to participate.

$ ______________________ x __________________________ = $ ________________________________

Monthly Contribution $315 | # Months Remaining in Plan Year | Per Pay Pre-Tax Contribution

☐ **No,** I do not want to participate

☐ **I do not want to participate in both the Healthcare Flexible Spending Account AND Commuter Reimbursement Account**

## EMPLOYEE AUTHORIZATION

*You are eligible to participate in the flexible spending account plans the first of the month following 90 days of employment. I certify that I am not a sole proprietor, partner in a partnership or 2% or great shareholder in an S-corporation.*

*I authorize the above elections and the subsequent adjustments to my base annual salary. I am aware the Healthcare FSA has a grace period in which to submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited. I am aware the funds in the Commuter FSA will roll over into the next plan year. I understand that my Healthcare FSA election is binding for the entire plan year and cannot be altered, other than by my employer, unless I experience a qualifying life event.*

PLEASE SUBMIT THIS COMPLETED FORM TO THE BENEFITS DEPARTMENT.

**Employee Signature:** ______________________________ **Date:** ______________