

# Healthcare and Dependent Care Flexible Spending Account (FSA): Employee Enrollment and Salary Reduction Agreement

## Employee information

Name

Last 4 digits of SSN

Address

City

State

ZIP code

( )

Daytime phone

Email

Reason for election (check one):

Annual enrollment election

New employee enrollment

Qualifying life event

Effective date: \_\_\_\_\_ (completed by employer)

## Election and salary reduction for flexible spending account(s)

### Healthcare flexible spending account

I authorize a salary reduction of \$\_\_\_\_\_ per year (deducted in generally equal amounts per pay) to my healthcare FSA (maximum per year of \$2,850 for 2022\*).

### Dependent care flexible spending account

I authorize a salary reduction of \$\_\_\_\_\_ per year (deducted in generally equal amounts per pay) to my dependent care FSA (maximum per year of \$5,000; \$2,500 if married, filing separately\*).

\* The IRS has not yet released limits for 2023. The 2023 limits will be available on [pensions.org/members](https://pensions.org/members) when released by the IRS.

## Acknowledgment, acceptance, and signature

I understand and accept the following terms and conditions:

- This authorization will be in effect for the plan year specified by the effective date. Elections for FSAs must be made on an annual basis.
- By completing and signing this form, I am authorizing my employer to withhold wages from my salary to be contributed to healthcare and/or dependent care FSAs.
- I understand that these enrollment elections and my authorization to withhold my FSA contributions cannot be changed except during annual enrollment or upon a qualifying life event.
- I am responsible for initiating any change in my elections due to a qualifying life event, as described under the plan, within 60 days of such event. Any contributions or changed contributions must be made after the changed contribution is submitted; retroactive changes are not permitted.
- Any contributions that are not used for reimbursement of allowable expenses during the benefits period (as defined in the plan) are forfeited at the end of that period.
- I affirm that neither I nor my spouse contribute, or will contribute, to a health savings account (HSA) while enrolled in an FSA.

Employee's signature (required)

Date