2024 IRS Maximum:
Dependent Care FSA - $5,000/annual ($2,500 for married individuals filing a separate tax return)

Health Care FSA - $3,200/annual

Limited Health FSA - $3,200/annual

2024 FSA (DepCare, Health, Limited) ENROLLMENT/CHANGE FORM

Important: Bank verification protocols require you to have a valid e-mail address and an active phone number when opening FSA/HSA. Additionally, P.O. Box are not considered as a valid address.

New enrollment ☐ Change in Contribution ☐

Employer:_____ Division (if applicable): _____

Employee name:_____ SSN Last 4 Digits:_____
Last First MI

Date of birth: _____ Home address: _____

City:_____ State:_____ Zip:_____ E-mail: _____

Payroll Frequency: ☐ Weekly (52) ☐ Biweekly (26) ☐ Semimonthly (24) ☐ Monthly (12) ☐ Other _____

Date of hire: _____ Effective date: _____

Benefit Election Authorization or Waiver

Enter the annual amount of your allocation(s) for the Plan Year to the account(s) of your choice and divide by the number of paychecks you receive during the Plan Year to arrive at the amount of your salary reduction each paycheck.

Benefit Elections: Annual Election

A. **Dependent Care Flexible Spending Account (FSA)**

- Dependents to be covered:

1. **Dependent 1** – Relationship:_____
   First Name:_____ Middle Name:_____ Last Name:_____
   Date of Birth:__/__/____ SSN:_____ Gender:_____
   $_____
   O Annual (Divided to the remaining pay periods of the year
   O One Time Deduction

2. **Dependent 2** – Relationship:_____
   First Name:_____ Middle Name:_____ Last Name:_____
   Date of Birth:__/__/____ SSN:_____ Gender:_____

3. **Dependent 3** – Relationship:_____
   First Name:_____ Middle Name:_____ Last Name:_____
   Date of Birth:__/__/____ SSN:_____ Gender:_____

B. **Health Care Flexible Spending Account (FSA)**
   $_____
   O Annual (Divided to the remaining pay periods of the year
   O One Time Deduction

C. **Limited Flexible Spending Account (LFSA)**
   $_____
   O Annual (Divided to the remaining pay periods of the year
   O One Time Deduction

Total Authorized Pre-tax Salary Reductions

☐ Waiver of Participation in Health FSA, Limited FSA and Dependent Care FSA.
After careful consideration, I have chosen not to participate in the FSAs for the current Plan Year.

D. Premium Payment (Pre-Tax)

Contributions to the employer-sponsored benefit plan(s). Per Pay Period $_____**

☐ Waiver of Participation in Pre-tax Premium Payment.
After careful consideration, I have chosen not to participate in the pre-tax premium portion of the Plan.

**This amount can be automatically increased or decreased during the Plan Year to correspond with increases or decreases in the amount of Employee contributions required by Employer to its benefit plans.

By signing below, I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified.
- I understand that I am not permitted to change my elections during the Plan Year unless the change is on account of and consistent with current recognized IRS regulations and change in status events.
- I also understand that unused account balances in my Dependent Care and Health FSAs at the end of the Plan Year or Plan's grace period are subject to forfeiture, based on applicable IRS law and regulations and Plan design.

Employee Signature:	Date: