PLAN PARTICIPATION FSA

To participate in a Flexible Spending Account (FSA) Plan, with a plan effective date of _____, please fill out this form.

ACCOUNTHOLDER INFORMATION			
Name:		Company:	
Email:		Department/Division:	
Home Phone:		Work Phone:	
Date of Birth:		Hire Date:	
Home Address:		First Payroll Effective Date:	
		Remaining # Pay Periods this Plan Year:	
SSN:		Pay Frequency:	

MEDICAL FLEXIBLE SPENDING ACCOUNT

☐ I elect to contribute $ _____ (before taxes) per pay period, which is $ _____ per plan year, to fund my account for reimbursement of qualified out-of-pocket healthcare expenses not covered under my health and other insurance plans.

☐ I decline to participate in this option for this plan year.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

☐ I elect to contribute $ _____ (before taxes) per pay period, which is $_____ per plan year, for funding reimbursement of qualified dependent daycare expenses. (Maximum amount per calendar year is the lesser of: (1) $5,000 for married filing joint, or $2,500 for married filing separate; (2) your spouse's total annual compensation; or (3) of your total annual compensation. If you are single, the maximum amount is $5,000.

☐ I decline to participate in this option for this plan year.

LIMITED FLEXIBLE SPENDING ACCOUNT AGREEMENT

☐ I elect to contribute $ _____ (before taxes) per pay period, which is $_____ per plan year, for funding reimbursement of qualified Limited FSA expenses. A Limited FSA may cover dental, vision, and post-deductible expenses.

☐ I decline to participate in this option for this plan year.

POST-TAX FLEXIBLE SPENDING ACCOUNT

☐ I elect to contribute $ _____ (after taxes) per pay period, which is $ _____ per plan year, for funding reimbursement of qualified out-of-pocket healthcare expenses not covered under my health and other insurance plans.

☐ I decline to participate in this option for this plan year.

PREMIUM ONLY PLAN

☐ I have enrolled in certain employer-sponsored insurance benefits. I understand that my share of the premium for these insurance benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my taxable income will automatically be adjusted to reflect that increase or decrease.

☐ I decline to participate in this option for this plan year.

WAIVER OF TAX BENEFITS

☐ I have been given the opportunity to enroll in these tax-savings plans and have declined to participate. I understand that I will lose all tax savings that I may have received as a participant.

My employer and I agree that my taxable income will be reduced each pay period by the amounts set forth in this agreement. I understand that I may change my election in the event of certain changes in my status. Prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. Any qualified expenses that are submitted by me will be reimbursed to me on a tax-free basis. Any contributions that are not used during the plan year may not be paid to me in cash. I acknowledge that I have received, read, and understand the Summary Plan Description.

Signature: _____ Date: _____

paylocity