

# Flexible Spending Account (FSA) Employee Participation and Compensation Reduction Agreement

For \_\_\_\_\_ for Plan Year \_\_\_\_\_ to \_\_\_\_\_.  
Employer (company name) start date end date

Employee Name: (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Office use only: EID \_\_\_\_\_)

Home Address: (number and street) \_\_\_\_\_  
(city, state, zip) \_\_\_\_\_

The best phone number to call to reach me about my Flex account is: ( \_\_\_\_\_ ) \_\_\_\_\_  
This is my:  Work phone /  Home phone /  Cell phone

Email Address: \_\_\_\_\_  
(Please provide your email. It will only be used to contact you about your account or to provide you with account updates.)

Direct Deposit – To have your manual claim reimbursements deposited directly to your checking or savings account, please obtain a copy of the Direct Deposit Authorization form and submit it with this Employee Participation Agreement.

Benefit Card – If your Plan provides a benefit card (MasterCard) for use with your FSA account and you already have a card from the prior plan year, keep your card. Just like other credit cards your FSA card is good until the expiration date on the card.

### Election of Health Flexible Spending Account

\_\_\_\_ I **elect** to participate in the **Health Flexible Spending Account (FSA)** for the Plan Year indicated above.

The amount of compensation reduction (my annual contribution) will be \$ \_\_\_\_\_ for the Plan Year. The funds in my Health FSA account will only be used to reimburse qualified out-of-pocket healthcare expenses that are incurred by me and my dependents, and expenses not covered by other insurance plans.

\_\_\_\_ I **decline** to participate in the health FSA for this Plan Year. (Office use only: \_\_\_\_\_ / pay pd.; Freq: \_\_\_\_\_)

### Election of Dependent Care Flexible Spending Account

\_\_\_\_ I **elect** to participate in the **Dependent Care Flexible Spending Account (DCA)** for the Plan Year indicated above.

The amount of compensation reduction (my annual contribution) will be \$ \_\_\_\_\_ for the Plan Year. The funds in my Dependent Care FSA account will only be used to reimburse qualified dependent care expenses. [The maximum amount per calendar year is the lesser of: (1) \$5,000 for married filing jointly or \$2,500 for married filing separately; (2) your spouse's total annual compensation; or (3) one-half of your total annual compensation. If you are single, the maximum amount is \$5,000.]

\_\_\_\_ I **decline** to participate in the DCA for this Plan Year. (Office use only: \_\_\_\_\_ / pay pd.; Freq: \_\_\_\_\_)

Please indicate the frequency of your pay periods. If you are uncertain, please ask your Human Resources Representative.

- Weekly    Semi-monthly (24 cycles/yr)    Monthly (date: \_\_\_\_\_)    Bi-weekly (26 cycles/yr)  
 Annually (month/date: \_\_\_\_/\_\_\_\_)    Other: (specify): \_\_\_\_\_.

By signing below, I understand that:

- I am authorizing my employer to reduce my compensation by the amount(s) specified above.
- If I have enrolled in employer-sponsored insurance benefits my share of the premium for these insurance benefits will automatically be paid with pre-tax dollars, and 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 accordingly.
- I have received and read the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations that I have under the Plan.
- I cannot change or revoke any of my elections or this compensation agreement at any time during the Plan Year unless I have a recognized change in status and my election is consistent with such change.
- Any funds that are not used during the Plan Year or within the specified Grace Period, if this option is offered under my employer's Plan, will be forfeited and may not be paid to me in cash or used to provide benefits in a later Plan Year.
- Prior to the first day of each Plan Year I will be offered the opportunity to change my benefit elections for the following Plan Year. In order to participate in the new Plan Year I must complete and return a new election form at that time.
- If I cease my employment with the Employer my participation in the Health Flexible Spending Account will be subject to the continuation coverage rules of COBRA, provided that my Employer is required to offer COBRA.

\_\_\_\_\_  
**Employee's Signature (Required)**

\_\_\_\_\_  
**Date**

**HR Department:** For mid-year new-hire, change-in-status, etc., please specify eligibility date: \_\_\_\_\_ and date of first payroll deduction: \_\_\_\_\_.



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