Your Hospital's Logo Here

FLEXIBLE SPENDING ACCOUNT

Election Form & Salary Reduction Agreement

EMPLOYEE NAME (Print):		HIRE DATE:
SOCIAL SECURITY NUMBER:		DATE OF BIRTH:
ADDRESS:		
CITY:	STATE:	ZIP:

	Annual Contribution Amount
Health Care Flexible Spending Account: ** (Not to Exceed $2,000)	$ _____
Dependent Care Flexible Spending Account: ** (Not to Exceed $5,000 if filing jointly; $2,500 if filing seperately)	$ _____
Total Annual Contribution	$ _____

	Pay Period Amount
Per Pay Period Amount (1/26th of Annual)	$ _____

** *minimum contribution amount is $5.00 per pay period*

I have read the enrollment information more fully describing the Flexible Spending Account plan. I elect the above amounts for contribution into the Health Care and/or Dependent Care Flexible Spending Accounts. I also understand that this election may not be changed during the Plan Year unless there has been a qualified change in status.

_____ Employee Signature

_____ Date

FOR HR USE ONLY:

		Date / Initials
Verification of Eligibility:	☐ Yes	_____
Verification of Pay Period Amount:	☐ Yes	_____
Deduction Turned On:	☐ Yes	_____