



FLEXIBLE SPENDING ACCOUNT ELECTION FORM

Client Name: _____

Employee Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

MEDICAL FLEXIBLE SPENDING ACCOUNT

Maximum annual contribution is \$3,500.00

\$ _____ per pay period x _____ number of deductions = \$ _____ annual election

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Maximum annual contribution is \$5,000.00

\$ _____ per pay period x _____ number of deductions = \$ _____ annual election

I have received a summary of tax rules, operational guidelines, and reimbursement procedures for use in Medical and Dependent Care FSA plans. I understand the plan document will control any contrary oral representation by any person. I understand that reimbursement will be available only for eligible expenses, and I agree to notify the employer if I receive reimbursement for an expense that does not qualify. I also agree, upon demand, to indemnify and reimburse the employer for any liability it may incur for failure to withhold taxes from any reimbursement I receive for non-qualified expenses, up to the amount of additional tax owed by me. Furthermore, I understand that any account surplus at the end of the year shall be retained by the employer to offset administrative expenses or future costs, and the obligation to make reimbursements is the responsibility of my employer and not any service provider hired by the employer to assist in processing claims.

I understand that I cannot make any changes (increase or decrease) to my election until the start of a new plan year, or I experience a life event change (i.e., marriage, divorce, birth/adoption of a child, etc.).

Employee's Signature: _____ Date: _____