ARCHER & GREINER PC
ATTORNEYS AT LAW

FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM

1. PARTICIPANT INFORMATION

Name (please print):	Social Security Number / EE ID Number:	
Address:	Date of Birth (MM/DD/YYYY):	Gender:
City:	State:	ZIP:
Cell Phone Number:	Home Phone Number:	

Marital Status: ☐ Single ☐ Married ☐ Married Filing Separately

2. HEALTHCARE FLEXIBLE SPENDING ACCOUNT

The Healthcare FSA allows you to set aside pre-tax dollars via payroll deductions to pay for qualified healthcare expenses for you and your dependents.

☐ Yes, I want to participate.

$ _____ ÷ _____ = $ _____

2027 Plan Year Contribution: $3,400* # Pay Periods in the Plan Year Per Pay Pre-Tax Contribution

☐ No, I do not want to participate.

** Pending 2027 Contribution Limits*

EMPLOYEE AUTHORIZATION

You are eligible to participate in the flexible spending account plans the first of the month following 90 days of employment. I certify that I am not a sole proprietor, partner in a partnership or 2% or greater shareholder in an S-corporation.

I authorize the above elections and the subsequent adjustments to my base annual salary. I am aware that the Healthcare FSA has a grace period during which I may submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited. I understand that my Healthcare FSA election is binding for the entire plan year and cannot be altered, other than by my employer, unless I experience a qualifying life event.

PLEASE SUBMIT THIS COMPLETED FORM TO THE BENEFITS DEPARTMENT.

Employee Signature: _____ Date: _____