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

Please check (✓) one box

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.

$ _____ **÷** _____ **= $** _____

2025 Plan Year Contribution $3,300 | # Pay Periods in the Plan Year | Per Pay Pre-Tax Contribution

☐ **No,** I do not want to participate

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 great shareholder in an S-corporation.

I authorize the above elections and the subsequent adjustments to my base annual salary. I am aware the Healthcare FSA has a grace period in which to 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:** _____