Flexible spending account (FSA) employee enrollment form

HealthEquity®

Please return this form to your HR department.

Employer information

Employer name

Account holder information

First name	M.I.	Last name	
SSN	Gender ☐ Male ☐ Female	Date of birth (mm/dd/yyyy)	
Email address		Home phone	
Physical street address	City	State	ZIP
Mailing address (if different)	City	State	ZIP

FSA coverage

Coverage effective date

Annual elections

	Contribution per pay period	Number of pay periods remaining in plan year		Your annual election amount
Flexible spending account	$ 0.00	X 0	=	$ 0.00
Limited purpose flexible spending account (LPFSA)	$ 0.00	X 0	=	$ 0.00
Dependent care flexible spending account (DCRA)	$ 0.00	X 0	=	$ 0.00
Contribution per pay period x number of pay periods = your annual election amount				

Signature

☐ I decline to participate in the FSA plan.

Print name	Signature	Date