

**FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM**  
**PLEASE COMPLETE THIS FORM AND SUBMIT TO YOUR EMPLOYER**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Hire \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
☐ (Check Here if Mobile Number)

E-mail Address \_\_\_\_\_

**Option I: Medical Flexible Spending Account**

Enter an **ANNUAL** PRE-TAX contribution election up to maximum\*: \$ \_\_\_\_\_

**Option II: Limited Purpose FSA** *(Dental & Vision ONLY)*

Enter an **ANNUAL** PRE-TAX contribution election up to maximum\*: \$ \_\_\_\_\_

**Option III: Dependent Care Reimbursement Account**

Enter an **ANNUAL** PRE-TAX contribution election up to maximum\*: \$ \_\_\_\_\_

**Option IV: Transit Pre-Tax**

\$ \_\_\_\_\_

**Transit Post Tax**

\$ \_\_\_\_\_

**Option V: Parking Pre-Tax**

\$ \_\_\_\_\_

**Parking Post Tax**

\$ \_\_\_\_\_

**Option VI: Waiver of Tax Benefits**

☐

I have been given the opportunity to enroll in these tax-savings plans and have declined to participate. I understand that I will lose all tax savings that I may have received as a participant.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Employer Use Only**

**Effective Date:** \_\_\_\_\_