# Flexible spending account (FSA) employee enrollment form

HealthEquity®

**Please return this form to your HR department.**

## Employer information

Employer name
John's Family, Inc.

## 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 |
|---|---|---|
| | | |