

# 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 <input type="checkbox"/> Male <input type="checkbox"/> 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	\$	X	=	\$
Limited purpose flexible spending account (LPFSA)	\$	X	=	\$
Dependent care flexible spending account (DCRA)	\$	X	=	\$

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
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