# 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

| | | | | Your annual election amount |
|---|---|---|---|---|
| **Flexible spending account ($3300 max)** | | | | $ |
| **Dependent care flexible spending account (DCRA 2500 S/$5000 M )** | | | | $ |

## Signature

☐ I decline to participate in the FSA plan.

| Print name | Signature | Date |
|---|---|---|
| | | |