Flexible Spending Account Election Form - 2025

SECTION 1: Employee Contact information

EMPLOYEE NAME: LAST | FIRST/MIDDLE INITIAL

SSN: | POSITION:

DAYTIME PHONE NUMBER: | EMAIL ADDRESS ❍ check if new

HOME ADDRESS: STREET ❍ check if new CITY | STATE | ZIP

SECTION 2: Election Information

Health Care Reimbursement Plan

❍ I elect to participate.

$______________is my PRE-TAX annual election.
Cannot exceed $3,300 annually.

❍ I elect NOT to participate.

Dependent Care Reimbursement Plan

❍ I elect to participate.

$ ______________ s my PRE-TAX annual election. *Cannot exceed $5,000 annually or $2,500 for an employee who is married and filing a separate tax return).*

❍ I elect NOT to participate.

HealthEquity Visa Debit Card

❍ I would like to receive one additional HealthEquity Visa Debit Card for use by an eligible dependent.

DEPENDENT NAME: LAST | FIRST | MIDDLE INITIAL

SOCIAL SECURITY NUMBER | DATE OF BIRTH

By signing this form, I understand that I am authorizing funds to be taken from my paycheck on a PRE-TAX basis and transferred into my Flexible Spending Account. The amount that I am requesting to be deducted will reduce my annual taxable wages. I understand that my election in to the Health Care and Dependent Care Plan(s) cannot be changed during the plan year unless I experience a qualifying change in status. My election into the Parking Plan and/or Transit Plan may be changed on a monthly basis.

X

EMPLOYEE SIGNATURE VERIFICATION **DATE**

FOR EMPLOYER USE ONLY:

Employee Division: ______________________________

Entered Date: ______________________________

Effective Date: ______________________________