

2027 FSA Employee Enrollment Form

Section I – To Be Completed by HR

Enrollment Type: ☐ New Hire ☐ Open Enrollment ☐ Change in Election ☐ Other:	Employer:	Date of Hire:
		Payroll Schedule:
		Enrollment Effective Date:

Section II – Employee Information – To be completed by employee

Employee Name			Social Security Number	
Home Address			City, State, Zip	
Telephone Number	Date of Birth	Gender: ☐ Male ☐ Female	Email Address:	

Section III – Employee FSA Election – (Please indicate your per payroll elections for FSA)

☐ <u>Medical FSA</u> ☐ <u>Waive Coverage</u>	<u>Annual Election:</u> \$ \$3,400 per plan year max. (For out-of-pocket Medical, Dental and Vision expenses for you, your spouse, and your dependent children. <u>Not allowed alongside an HSA</u>)
☐ <u>Limited FSA</u> ☐ <u>Waive Coverage</u>	<u>Annual Election:</u> \$ \$3,400 per plan year max. (For out-of-pocket, Dental and Vision expenses for you, your spouse, and your dependent children. (Allowed alongside an HSA)
☐ <u>Dependent Care FSA</u> ☐ <u>Waive Coverage</u>	<u>Annual Election:</u> \$ \$7,500 per calendar year, OR \$2,500 if married filing separately. (For expenses related to childcare of a dependent child or eldercare for elders living in your home which enables you to work).

My signature below indicates that I have read and understand this election form and the descriptive material provided. This election is binding on me and cannot be revoked or modified except under limited circumstances as established by MEDSURETY, LLC and the IRS.

I authorize MEDSURETY, LLC to enroll me in the plans I have elected and to reduce my pay by the agreed upon amount(s). I further understand that any contributions for flexible spending accounts will be on a pre-tax basis.

I declare that the information furnished on this form is true, correct, and complete to the best of my knowledge.

Signature: _____ **Date:** _____

