Payroll Dynamics

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FSA MEDICAL & DEPENDENT CARE ELECTION FORM

You are required to complete this election form at the beginning of each Plan Year.
A new election form should also be completed if you require a change to your annual election amount(s).

Plan Year 2024 **Company Name**_____

Part A. Employee Information (All Fields Are Required)

Name_____ Date of Birth_____ Date of Hire_____

Address_____ City, State, Zip_____

Social Security #_____ Phone Number_____

Email_____

Part B. Elections (Select one or more options)

Medical Care Pre-tax Annual Election_____ Plan Year 2024 Annual Limit $3,200.00

Dependent Care Pre-tax Annual Election_____ Plan Year 2024 Annual Limit $5,000.00

Part C. Benefits Card

Do you want to order a benefits card associated with your account? ◯ Yes ◯ No

A $15 charge will be assessed for lost or stolen cards that need to be cancelled and reissued. A $10 expedited shipping charge is applicable if rush shipping is selected.

If you wish to have a separate card issued for a dependent, a $15 per card fee applies.

Part D. Plan Agreement I understand that: For Calendar Year Plans

1. My compensation each pay period will be reduced by the total amount above divided by the number of company pay periods in the year (or remaining in the year if you are becoming a participant at any time except at the beginning of a plan year).
2. I cannot change or revoke this benefit election as of any date prior to the next January 1st, unless I have a change in my family status or Life Change Event (i.e. marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Administrator determines will permit a change or revocation of an election).
3. Prior to January 1st each year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I do not complete and return a new Election Form at that time, I will be treated as having elected cash instead of salary reductions for the new plan year (January 1st to December 31st).
4. The administrator may reduce or cancel the amount of my pay reduction or otherwise modify this agreement in accordance with the provisions of the Plan if it is believed to be advisable in order to satisfy certain provision of the Internal Revenue Code.
5. This benefit election will automatically be cancelled as of the date of my termination of employment. However, if you continue to be covered under the Employer's medical plan or plans, you may be able to continue participation in this plan during your period of coverage. You will receive information on this option when you terminate service.

I hereby authorize my employer to deduction from my salary, or other compensation, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan.

Employee's Signature_____ Date_____

Accepted and agreed to by (Employer's Signature)_____ Date_____