The Employer Group
The Human Resource Resource™

2024 Flexible Spending Account Enrollment Form

Name:_____

Last 4 Digits of Social Security Number: _____

Client Company: _____

Hours work/week (must be working 30 hours or more and be at least 19 years old) _____

☐ **YES, I wish to Enroll in the Flexible Spending Plan.**

Please reduce my gross earnings for 2024 by pro-rated amounts (the total calendar year election divided by the number of regular pay periods following my plan participation) to fund the following Flexible Spending Account Plan(s):

Medical Out-of-Pocket Expenses (Maximum $3,050) $_____(annually)

Dependent Care Expenses (Maximum $5,000 for single and married filing joint, $2,500 for married filing separate.) $_____(annually)

I hereby authorize my employer to reduce my annual earnings by the amounts and for the purposes indicated above. I understand and agree as follows:

- This amount will be deducted from my regular paychecks following my first day of plan participation. I understand that plan participation does not begin until the first of the month following my date of hire or, for current employees enrolling during Open Enrollment, January 1st.
- If my pay for any period is insufficient to cover a deduction, a partial deduction will be made; the remaining deduction will be taken from my future paycheck(s).
- I can be reimbursed only for qualified expenses incurred during the plan year (January 1, 2024 or my first date of plan participation, whichever occurs later, through March 15, 2025, or, if earlier, until participation ends). For terminated employees, participation ends on the last day of employment.
- This authorization is irrevocable and no modification will be allowed, except for a legal change in status, or as otherwise allowed under the plan.

I further understand that, pursuant to the Internal Revenue Code, any amount remaining in my spending account(s) after I have been reimbursed for qualified expenses incurred through March 15, 2025 will be forfeited. I also understand that I will have until April 30, 2025 to submit my 2024 expenses for reimbursement. I have read the plan summary and understand the conditions and limits of my election and participation in the plan. I understand that I may not participate in both an HSA and an FSA.

Signature_____Date_____

☐ **NO, I do not wish to participate.** I hereby waive my right to enroll in the plan for the 2024 plan year.

Signature_____Date_____