

FSA/DCAP ELECTION FORM

122 Parish Drive, Wayne, NJ 07470

Employer Name:			
Employee Last Name, First Name:			Social Security #:
Home Address (include apt #):			Date of Birth:
City	State:	Zip:	Date of Hire:
Email Address:	Phone #:	Gender M/F:	Marital Status S/M/D/W:

DEPENDENTS TO BE COVERED UNDER THE FSA

Last Name	First Name	Relationship	Date of Birth

AUTHORIZATION OR WAIVER OF PARTICIPATION

Medical Care Spending Account

I elect to participate in the Medical Care FSA. I direct my employer to reduce my annual salary for the current Plan Year by \$_____ (\$2,750 maximum)


I do not elect to participate in the Medical Care FSA

Dependent Care Spending Account

I elect to participate in the Dependent Care FSA. I direct and authorize my Employer to reduce my annual salary for the current Plan Year by \$_____ (\$5,000 if MFJ/Single, \$2,500 all other tax statuses)

I do not elect to participate in the Dependent Care Spending Account

I hereby apply for the options listed above. I authorize my employer to adjust my pay as required by my election. I acknowledge that my election is irrevocable and will remain in force throughout the plan year unless there is a change in my family status. A change in family status includes: marriage; divorce; death of the spouse or dependent; birth or adoption of a child; a change in the spouse's employment status; or termination. I WILL FORFEIT ANY UNUSED MONEY REMAINING IN MY ACCOUNT AS OF THE END OF THE PLAN YEAR OR WHEN MY PARTICIPATION IN THE PLAN ENDS.

 **Employee Signature:** _____ **Date:** _____

Please return this form to your Benefits/Human Resources Administrator

----- **FOR EMPLOYER USE ONLY** -----

* Required Fields / Must be completed for enrollment to be processed

Pay Cycle: ___ Weekly ___ Bi-Weekly ___ Semi-Monthly ___ Monthly	Plan Effective Date: ___/___/_____
Salary Reduction Will Begin: ___/___/_____	Pay Cycle Deduction Amount \$ _____
Employer Representative Signature:	Date: ___/___/_____

Note: Partners, Sole Proprietors, Owners of an LLC and 2% or more owners of a sub-chapter S Corporation are not permitted to participate in a Medical FSA program.