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Employee Benefits and HR Solutions
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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 $_____($3,200 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.

Phone 1-973-995-1000 Toll free: 1-866-693-7254 Fax 1-973-832-4499