Payroll Deduction Authorization Form

For the employees of:	
Payroll schedule:	
Plan Year:	
Number of pay periods per year:	

Flexible Spending Accounts	Plan Maximum		Per pay period deduction	Annual Election Amount	Waived
☐ Medical FSA	Maximum per pay period	$	$	$	☐
	Maximum annual benefit for the year	$			
☐ Dependent Care FSA	Maximum per pay period	$	$	$	☐
	Maximum annual benefit for the year	$			

Total Per Pay Period Deduction	$

I have received and read the Cafeteria Plan enrollment materials provided by my employer. I understand that by signing and submitting this form, I am making a binding election for my benefits and pay for the plan year indicated on the front of this form. I also understand that I may not change my elections until the next plan year enrollment period unless I have a qualified change in my family status as explained in my enrollment materials. I authorize my employer listed above to make pre-tax deductions from my gross pay for medical reimbursement and dependent care reimbursement accounts. I understand that my Social Security benefits may be slightly reduced as a result of my election. This authorization will remain in effect until a new election form is completed and signed by the employee.

Reimbursement Methods

Reimbursement method preferred	
☐ Check	
☐ Direct Deposit	Must have authorization form on file

Employee Authorization

Participant Name (First MI Last)			**Social Security Number**			
Street Address						
☐ check if new address	**City**		**State**		**Zip Code**	
Phone Number			**Email Address* required**			
Date of Birth			**Date of Hire**			

Employee Signature		**Date**	

For employer use only:	Participant Effective date	Enrollment type		Date of first payroll deduction
		☐ Open Enrollment ☐ Change of Benefit Eligibility	☐ New Hire ☐ Other:	

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