Debit Card Cafeteria Plan Election Form

COMPANY NAME: _____

HEALTH INSURANCE COVERAGE TYPE: ☐ PPO ☐ HMO ☐ Spouse's plan

EMPLOYEE CURRENTLY ENROLLED IN: ☐ HRA ☐ HSA

Note: Enrollment in HRA or HSA may limit Healthcare FSA

EMPLOYEE INFORMATION:

Name:		Soc. Sec#:		Date of Hire:
Address:		Date of Birth:	Marital Status:	Gender M or F
City:		Number of Dependents:		Salary:
State:	Zip Code:	Phone Number:	Email Address:	

Add-On Dependent(s)	Dependent(s) Needing Cards (Check One)*	Date of Birth	Social Security#
Spouse:	☐ Y / N ☐		
Child:	☐ Y / N ☐		
Child:	☐ Y / N ☐		
Child:	☐ Y / N ☐		
Child:	☐ Y / N ☐		

***If not indicated, no card will be issued.**

ANNUAL ELECTIONS: Plan Year Start Date: Employee Coverage Start Date:

	Annual Election	Per Pay Period Deduction	First Payroll Deduction Date
Healthcare Flexible Spending Account			
Dependent Care Spending Account			
Transportation/Vanpooling			
Parking			

AUTHORIZATION: By signing this form I acknowledge that I am authorizing the company to deduct equal amounts from my paychecks to collect the designated pre-tax amount indicated above. I recognize that these selections constitute a deliberate binding decision on my part that shall not be changed until the enrollment period for the next plan year or if I experience a change in status.

_____ _____

Employee Signature **Date**

If you elect not to participate in the FSA plan, please sign and date the form below.
I elect *NOT* to participate in the FSA program at this time.

_____ _____

Employee Signature **Date**

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