

# C-Lect - Flexible Spending Account (FSA)

Annual Minimum $130.00 to Annual Maximum $2,650.00 Bi-weekly per pay deduction $5.00 to $101.92

|  |  |  |  |
| --- | --- | --- | --- |
| Employee’s Name (Last, First, Middle) | Social Security Number |  | Date of Birth |
| Employee’s Address | City | State | ZIP |

Employee Number Department Date Employed

Dependent Information

|  |  |
| --- | --- |
| Spouse’s Name | Date of Birth |
| Dependent Name | Date of Birth |
| Dependent Name | Date of Birth |
| Dependent Name | Date of Birth |
| Dependent Name | Date of Birth |
| Dependent Name | Date of Birth |
| I request that my salary be reduced per pay period as follows: $ |  |

## Authorization for Flexible Spending Account

Authorization: I certify the above information to be correct and true to the best of knowledge and that the children based under "Dependent Coverage" either reside with me in a parent-child relationship or are legally dependent on me for support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_