HealthPartners

EMPLOYER SPENDING ACCOUNT ENROLLMENT/CHANGE FORM

Employer name:

EMPLOYEE INFORMATION: all fields required ☐ **Employee information has changed**

Last name:	First name:	M.I.:
Address:		
City:	State:	Zip Code:
Email address:		Gender:
Social Security Number/Employee ID:	Date of Birth:	
Site:	Payroll mode (weekly, biweekly, etc.):	

Debit card (select one only if your group offers a debit card option): ☐ Yes ☐ No

Election information:	**Effective date:**	**First payroll deduction date:**
☐ New enrollee		
☐ Mid-year change		
☐ Termination or canceling plan		(last date)

CONTRIBUTION AMOUNTS:

		EMPLOYEE CONTRIBUTION		**EMPLOYER CONTRIBUTION (if any)**	
Account	**IRS maximum**	**Total annual election**	**Payroll deduction amount**	**Total annual election**	**Payroll deduction amount**
☐ Health care flexible spending account (FSA)	$2,850/year	$	$	$	$
☐ Limited-use health care FSA (if contributing to an HSA while enrolled in the FSA)	$2,850/year	$	$	$	$
☐ Dependent care reimbursement account (DCRA)	$5,000/year	$	$	$	$
☐ Transit account	$280/month	$	$	$	$
☐ Parking account	$280/month	$	$	$	$

EMPLOYER SIGNATURE:

Signature: Date:

Email form to your HealthPartners FSA Financial Analyst or fax to 952-883-5026 or 877-624-2287. If emailing the form, please remember to send through secure email.