Flexible Spending Account (FSA) Employee Enrollment Form

HealthEquity®
Building Health Savings℠

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Reimbursement Accounts**
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020

Fax: 801.407.1792

Employer Information

Employer Name

Account Holder Information

First Name	M.I.	Last Name	
SSN	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	
E-mail Address		Home Phone ( )	
Physical Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP

Insurance Coverage

Coverage Effective Date	Coverage Type ☐ Single ☐ Family

Annual Elections

	Contribution Per Pay Period	Number of Pay Periods Remaining in Plan Year		Your Annual Election Amount
Health Care Flexible Spending Account	$	X	=	$
Limited Purpose Health Care Flexible Spending Account	$	X	=	$
Dependent Care Flexible Spending Account	$	X	=	$

Contribution Per Pay Period x Number of Pay Periods = Your Annual Election Amount

Signature

☐ I decline to participate in the FSA plan.

Print Name	Signature	Date