archcare
The Continuing Care Community
of the Archdiocese of New York

2024 FSA Deduction Form

Please read all materials before completing this form.

FACILITY/PROGRAM: _____

Please print clearly:

_____

Last Name First Name SSN

_____

Phone Number

Medical FSA Contributions:

☐ I elect to contribute $_____for the year 2024. Maximum of $3,050.
I understand that this amount will be divided by the number of paychecks in the year and deducted from my paycheck.

Dependent Care FSA Contributions:

☐ I elect to contribute $_____for the year 2024. Maximum of $5,000.
I understand that this amount will be divided by the number of paychecks in the year and deducted from my paycheck.

I elect to participate in the Flexible Spending Account plan for the upcoming 2024 plan year. I understand that I can contribute to my Benefit Resources Account and to my Dependent Care Account each plan year.

Your Approval

I have read all the enrollment materials explaining this benefit. I understand that my contributions to each account can only be used to reimburse eligible expenses under each account and that I forfeit any funds remaining in my account at the end of the plan period. I further understand that I cannot change my contributions unless I have a qualified family status change and that my salary reduction contributions will continue for the remainder of the plan period unless a qualified change is made. My Social Security benefits may be reduced since Social Security taxes are not paid on my contributions. I authorize payroll reductions as contributions to my health and/or dependent care accounts as indicated above.

Care Member Signature_____ **Date** _____