Flexible Spending Account (FSA) employee enrollment form

HealthEquity®

Please return this form to your HR department.

Employer information

Employer name
iroquoiSystems, inc.

Account holder information

First name	M.I.	Last name	
SSN	Sex ☐ Male ☐ Female	Date of birth (mm/dd/yyyy)	
Email address		Home phone	
Physical street address	City	State	ZIP
Mailing address (if different)	City	State	ZIP

FSA coverage

Coverage effective date
01/01/2025

Annual elections

	Contribution per pay period	Number of pay periods remaining in plan year		Your annual election amount
Flexible spending account	$	X 24	=	$

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