

2022 FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION FORM

Participant Information & Election

This section to be completed by the Employee – Please print clearly

Last Name _____ First Name _____ M.I. _____

Employer _____

Social Security Number _____ Date of Birth _____

Email _____ Phone Number _____

2022 Medical Flexible Spending Account (FSA) Limit

2022 Maximum Plan Year Contributions = \$ 2,750

**Please note that to participate in the medical FSA your employer must offer group medical insurance and you must be eligible to participate in that plan.*

Annual Election \$ _____

Number of Pay Periods (if enrolling mid-year, please enter the number of remaining pay periods within the plan year) ÷ _____

Medical FSA Contribution per Paycheck \$ _____

Effective Date of Medical FSA Election _____

This deduction should continue through the plan year

This election should recur _____ times

This is a one-time election

I do not wish to participate

2022 Dependent Care Flexible Spending Account (FSA) Limit

2022 Maximum Plan Year Contributions = \$ 5,000

Annual Election \$ _____

Number of Pay Periods (if enrolling mid-year, please enter the number of remaining pay periods within the plan year) ÷ _____

Dependent Care FSA Contribution per Paycheck \$ _____

Effective Date of Dependent Care FSA Election _____

This deduction should continue through the plan year

This election should recur _____ times

This is a one-time election

I do not wish to participate

Employee Signature _____ Date _____

Submit Your Completed Application To:



Fronteer Professional Services, Inc.

4007 State Street Suite 20 · PO Box 1315
Bismarck, ND 58502

T: (701) 258-9848 · F: (701) 258-1011

E: customerservice@fppayroll.com

Contribution Information
This section to be completed by Fronteer Professional Services

Medical Flexible Spending Account

Employee Contributions (if applicable): Weekly Bi-Weekly Monthly Quarterly Annually
Annual Amount: \$ _____ / # of PP _____ = \$ _____ Date of First Deduction: _____
Employer Contributions (if applicable): Weekly Bi-Weekly Monthly Quarterly Annually
Annual Amount: \$ _____ / # of PP _____ = \$ _____ Date of First Deduction: _____

Dependent Care Flexible Spending Account

Employee Contributions (if applicable): Weekly Bi-Weekly Monthly Quarterly Annually
Annual Amount: \$ _____ / # of PP _____ = \$ _____ Date of First Deduction: _____