2023 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 ______________________

2023 Medical Flexible Spending Account (FSA) Limit
2023 Maximum Plan Year Contributions = $ 3,050
**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

2023 Dependent Care Flexible Spending Account (FSA) Limit
2023 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.
1838 E Interstate Ave Ste B · PO Box 1315
Bismarck, ND 58502
T: (701) 258-9848 · F: (701) 258-1011
E: customerservice@fpspayroll.com

Contribution Information
This section to be completed by Fronteer Professionall 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: ________________