# 2024 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 _____

**2024 Medical Flexible Spending Account (FSA) Limit**
2024 Maximum Plan Year Contributions = $ 3,200
**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

**2024 Dependent Care Flexible Spending Account (FSA) Limit**
2024 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

**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 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: _____