



**Employer FSA Setup Form**

**Part 1 - Company Information:**

Company Name:		Tax ID #:	
Street Address:	City:	State:	Zip:
Name of Executive Contact:		Title:	
Email Address:	Telephone:	Fax:	

**Part 2 - FSA Information:**

Number of Eligible Employees: _____	
What Type of Plan: <i>(please check and complete the necessary annual maximum contributions for employees)</i>	
<input type="checkbox"/> <b>Health Care Account</b> - Maximum Annual FSA Contribution: Individual = \$ _____	Family = \$ _____
<input type="checkbox"/> <b>Dependent Care Account</b> - Maximum Annual FSA Contribution: set by IRS	
<input type="checkbox"/> <b>Commuter Account</b> - Maximum Annual FSA Contribution: set by IRS	
Plan Effective Dates: _____	
New Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, current provider's name: _____	Original Effective Date: _____
Plan Year Start: _____	Plan Year End: _____
Do you want to offer a grace period: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you want to offer the rollover: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>* Please note, you can only offer the grace period or the rollover option. You cannot offer both in the same plan year.</i>	

**Part 3 - Debit Card Services:**

Will you be using the Debit Card: <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Part 4 - Company's Bank:**

Bank Name:	
Bank Account #	Routing #

**Part 5 - Authorization:**

1) I understand that London Health Administrators is the administrator of the FSA. 2) I understand that money to fund the eligible FSA expenses will be provided by the employer and/or employee's pretax paycheck contributions. 3) I authorize London Health Administrators to withdraw funds from the bank account named in Part 4 for my employee's eligible FSA expenses. 4) I certify that the information in this agreement is true and complete.	
Signature of Company Representative:	Date: