2027

State of Louisiana
Office of Group Benefits - Flexible Benefits Plan
Flexible Spending Arrangement Enrollment/Stop Form

*You must complete this form **each year** to participate in a tax-free Flexible Spending Arrangement. Please print.*

Note to FSA Enrollees: *By providing an email address, you may receive certain benefits-related correspondence through email. You are responsible to provide us with your current email address and to promptly notify us of any changes to your email address by contacting your agency's Human Resources department.*

Social Security Number	Email Address (preferred)	Payroll System	Agency Number

Last Name (Print)	First Name	Middle Initial

Home Address	City	State	Zip

Home Phone	Daytime Phone	Date of Hire	Number of Pay Periods	Date of Birth	Payroll Use only	
					Effective Date	**First Payroll Date**
ENROLLMENT STATUS QLE CODE _____						

Indicate the amount you wish to set aside via tax-free salary deduction by completing the sections below. Complete the worksheets provided in the Flexible Spending Arrangement (FSA) Handbook before deciding on the amount.

- In Box #1, indicate the dollar amount you elect to contribute for the plan year.
- In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year (9, 10, 12, 18, 24).*
- In Box #3, indicate the deduction amount per paycheck. (Note: If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly, to reflect rounding. By signing this form, you certify that you expect to receive the number of paychecks listed in Box #2.)
- In Box #4, indicate the annual FSA fee amount (12 months = $24.00). **
- In Box #5, indicate the FSA fee per pay period (paid biweekly is $1.00; paid monthly is $2.00). ***

*If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Type	*Dollar Amount*	*Number of Regular Payroll Checks**	*Deduction Amount per Paycheck*	*FSA Fee per Pay Period****
General-Purpose Health Care FSA (GPFSA)				
For eligible medical expenses incurred by you, your family members, or both ($600 minimum contribution; $3,500 maximum contribution)				
Limited-Purpose Health Care FSA (LPFSA)				
*For eligible **dental and vision** expenses **only** incurred by you, your family members, or both\. For employees who want to participate in an FSA **and** a Health Savings Account. ($600 minimum contribution; $3,500 maximum contribution)*				
Dependent Care FSA (DCFSA)				
*For eligible **DEPENDENT CARE EXPENSES** of an eligible dependent while you work ($600 minimum contribution)* *TAX FILING STATUS - CHECK ONE: _____ Married, filing separately (maximum $2,500) _____ Married, filing jointly (maximum $5,000)* *_____ Married with incapacitated spouse (maximum $5,000) _____ Single head of household (maximum $5,000) Single (maximum $2,500)*				

IMPORTANT: SALARY REDUCTION AGREEMENT ***(Please review the Flexible Benefits Plan Resource Documents)***

1. I hereby authorize my employer to reduce my gross salary (before federal and state income taxes are calculated) by the total deduction amount per pay period as indicated above. If applicable, I understand that this salary reduction might produce lower Social Security benefits.
2. I agree to file IRS Form 2441 regarding my Dependent Care FSA.
3. I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year (due to the IRS "use-or-lose" rule).
4. I understand that funds in one FSA cannot be used to reimburse expenses covered by another FSA.
5. I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
6. I understand that funds in any FSA can only be paid out for reimbursement of eligible expenses actually incurred during my period of coverage for the applicable plan year.
7. I understand that improper payments (ineligible expenses) may be withheld from my paycheck or reported as taxable income on my W-2. All claims must be substantiated prior to April 30, 2026.
8. I understand that the salary deduction amount will include the items specified above and will continue in effect unless I terminate employment or file an approved GB-01 form with the Human Resources office of my employer.
9. I understand and agree that my employer, the Office of Group Benefits and the Flexible Benefits Plan administrator will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year.

Employee Signature	Agency or Payroll System Name		Date Signed
Payroll Officer/Benefits Administrator	Phone Number	OGB Agency Number	Date Signed