

**2026  
Flexible spending account (FSA) employee enrollment form**



Please return this form to the HR department at HR@elmhurst.org.

<b>Employer information</b>	
Employer name CITY OF ELMHURST	

<b>Account holder information</b>			
First name	M.I.	Last name	
SSN	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)	
Email address		Home phone	
Physical street address	City	State	ZIP
Mailing address (if different)	City	State	ZIP

<b>FSA coverage</b>	
Coverage effective date 01/01/2026	

<b>Annual elections</b>			
	Contribution per pay period	Number of pay periods remaining in plan year	Your annual election amount
Flexible spending account	\$	X 26	= \$
Limited purpose flexible spending account (LPFSA)	\$	X 26	= \$
Dependent care flexible spending account (DCRA)	\$	X 26	= \$
Contribution per pay period x number of pay periods = your annual election amount			

<b>Signature</b> <input type="checkbox"/> I decline to participate in the FSA plan.		
Print name	Signature	Date

**2026 Annual Limits**

- **Medical FSA: \$3,400**
- **Limited Purpose FSA: \$3,400 to use with High-Deductible Plan to cover expenses for dental and vision claims only**
- **Dependent Care: \$7,500 for single taxpayers and married couples filing jointly or \$3,750 for married people filing separately**