

TENNESSEE BOARD OF REGENTS

Flexible Spending Account (FSA) Enrollment and Payroll Deduction Form - Plan Year 2027

Use this form to elect a Medical FSA, Limited Purpose FSA, and/or Dependent Care FSA (DCFSA) for the 2027 plan year. **New elections must be made each plan year.**

Section 1: Employee Information

Name _____
(Last, First, Middle initial)

Employee ID _____
Work phone _____

Mailing address _____
City/State/ZIP _____

Institution name _____
Payroll frequency: __12 __24 __Other _____

Section 2: 2027 FSA Limits

Account	2027 Maximum	Carryover
Medical FSA	\$3,400	Up to \$680
Limited Purpose FSA (vision and/or dental expenses only)	\$3,400	Up to \$680
Dependent Care FSA (DCFSA)	\$7,500	No carryover

Eligibility note: If you are enrolled in a HealthSavings CDHP/HSA, you are not eligible to contribute to a Medical FSA; however, you may contribute to a Limited Purpose FSA for eligible vision and/or dental expenses.

Section 3: Calculate Your FSA Election and Per-Paycheck Deduction

Complete the column for each account you wish to elect.

	Medical FSA	Limited Purpose FSA	Dependent Care FSA
A. Annual amount you elect for 2027	\$ _____	\$ _____	\$ _____
B. Number of regular paychecks expected in 2027	_____	_____	_____
C. A ÷ B =	\$ _____	\$ _____	\$ _____
Your per-paycheck deduction	\$ _____	\$ _____	\$ _____

Your annual election may not exceed the applicable 2027 maximum shown in Section 2.

Employee Authorization

By signing this form, I authorize my employer to reduce my gross salary on a pre-tax basis by the FSA election(s) shown above. I understand that this is not an application for medical or dental insurance and that FSA elections are subject to plan and IRS rules. I understand that unused DCFSA funds do not carry over to the next plan year. For the Medical FSA and Limited Purpose FSA, up to \$680 of eligible unused funds may carry over, subject to plan requirements. I understand that amounts above the permitted carryover are forfeited. I understand that this 2027 election replaces any prior FSA election for the new plan year.

Employee signature _____

Date _____

Benefits/Payroll Office Use

Total annual FSA election(s)	Paychecks remaining in 2027	Total deduction per paycheck
\$ _____	_____	\$ _____

Return this form to your personnel, payroll, or benefits office. Keep a copy for your records.