CANON MEDICAL SYSTEMS USA, INC.

2026 FLEXIBLE SPENDING ACCOUNTS CHANGE FORM

EMPLOYEE INFORMATION

Name: _____ _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL

Address: _____

Employee ID#: _____

CHANGES TO HEALTH CARE AND DEPENDENT CARE CONTRIBUTIONS

I elect to change my contributions to my Flexible Spending Account(s) due to a qualified family status change. Changes will be effective from the date of this change through the end of the Plan year.

I further understand that I may not change my contribution election(s) again unless qualified through another family status change.

The Limited Health Care FSA has a $3,300 maximum. If single or married and filing a joint federal income tax return, the Dependent Care FSA has a maximum of $7,500. This maximum may be reduced if you are married and filing separate income tax returns. This maximum may also be reduced if your spouse earns less than $5,000; contributes to his/her employer's FSA; is disabled; or is a full-time student.

In addition, the Limited Health Care FSA and Dependent Care FSA have a minimum monthly contribution of $10.00 ($5.00 per semi-monthly pay period).

I want the following amounts to be deducted from my paycheck for the following flexible spending account plans:

		Annual Contribution	Stop Contribution (initial below)
☐	Limited Health Care FSA	$	
☐	Dependent Care FSA	$	
	Total Annual Contribution	$	

YOUR APPROVAL

I understand that my contributions to the flexible spending account(s) can only be used to reimburse eligible expenses (under each account) and that, per IRS guidelines, I will forfeit any funds remaining in my account at the end of the plan period. (Note: Canon Medical Systems has arranged for a 90-day "grace period" after the end of the plan year. You will be able to file claims dated from the previous year within this 90-day period).

I further understand that my Social Security benefits may be reduced since Social Security taxes are not paid on my contributions. As indicated above, I authorize payroll deductions to serve as contributions to the Limited Health Care FSA and/or Dependent Care FSA.

_____ _____
Signature **Date**