Flexible Spending Account
Health Care and Dependent Care Enrollment

Employee Information

Employee ID Number	Name *(Last, First, Middle Initial)*	Date of Birth *(MM/DD/YYYY)*

Home Telephone Number	Business Telephone Number
( )	( )

Street Address	City	State	ZIP Code

Employer Information

Employer Name	Control Number
NEXCOM	**476694**

Annual Contribution

Complete the following section to elect the type(s) of flexible spending account plan(s) you wish to participate in and designate the annual contribution amounts.

I wish to participate in the following flexible spending account plans:

Annual Contribution

☐ Health Care FSA $ _____

(Pretax account for eligible healthcare expenses, minimum $200.00, maximum $3,200)

- ☐ Aetna Plan
- ☐ Non-Aetna Plan

☐ Dependent Care FSA $ _____

(Pretax account for eligible daycare expenses, minimum $200.00)

($5,000 maximum if single or married and filing joint federal income tax return; $2,500 if married and filing separate federal income tax returns.)

Total Annual Contribution $ _____

Authorization - Please read the following statements and then sign and date this form.

I authorize the reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that the amounts deducted from my pay and not used for eligible health care and/or dependent care expenses incurred the same year **will be forfeited** in accordance with IRS regulations.

I also understand that this authorization is irrevocable until the next election period unless I have a change in family status.

Authorized Signature	Date *(MM/DD/YYYY)*