



Flexible Spending Account Health Care and Dependent Care Enrollment

Employee Information

Social Security 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
---------------	----------------

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:

	<u>Annual Contribution</u>
☐ Health Care FSA (Pretax account for eligible healthcare expenses, minimum \$200.00, maximum \$3,400)	\$ _____
☐ Aetna Plan	
☐ Non-Aetna Plan	
☐ Dependent Care FSA (Pretax account for eligible daycare expenses, minimum \$200.00) (\$7,500 maximum if single or married and filing joint federal income tax return; \$3,750 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)
----------------------	-------------------