Flexible Spending Account
Health Care and Dependent Care Enrollment

Employee Information

SAP#	Name *(Last, First, Middle Initial)*	
Home Telephone Number ( )	Business Telephone Number ( )	
Street Address	City	State ZIP Code

Employer Information

Employer Name	Control Number
CNIC	838990

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 $3,300)

- ☐ 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)*