



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 NEXCOM	Control Number 476694
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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 \$3,300.00)
- ☐ 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)
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