



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

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|--------------------------------|---------------------------------|
| 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 \$3,200.00)
- 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) |
|----------------------|-------------------|