aetna

Flexible Spending Account
Health Care and Dependent Care Enrollment

Employee Information

Social Security Number	Name *(Last, First, Middle Initial)*	Date of Birthday (MM/DD/YYYY)

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 and designate the annual contribution amounts.

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

Annual Contribution

☐ Health Care FSA
(Pretax account for eligible Healthcare expense minimum $200.00 maximum $2,650)
- ☐ Aetna Plan
- ☐ Non-Aetna Plan

$_____

☐ Dependent Care FSA
(Pretax account for eligible Healthcare 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 $_____

Authorizations – 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 unused funds in my Health Care FSA can be carried over from year to year, up to a maximum of $500, if I am still in the plan on the last day of the plan year.
I understand that the amounts deducted from my pay and not used for eligible dependent care expenses incurred the same year **will be for 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)