Flexible Spending Account Enrollment

Employer:	Plan Year:	Plan Effective Date: Payroll Effective Date:
Employee Name:	Date of Birth:	Social Security No:
Home Address:	City/State/Zip:	
Phone Number:	Email: *	

** All plan communication pertaining to your account activity is provided solely via email and through our participant portal by signing in at www.NueAccount.com/Home. It is important to notify NueAccount if you change your email address.*

FSA Health Care Account - maximum*annual contribution is* $3,400		
☐ **Waive**	☐ **I elect to enroll in the Healthcare FSA for medical, vision and/or dental expenses**	**Contribution Election** **$ _____ pay period / $ _____ plan year**
Dependent Daycare Reimbursement - $7,500 *plan year maximum; $3,750 for married filing separately*		
☐ **Waive**	☐ **I elect to enroll in the Dependent Daycare FSA to be used for qualified dependent care expenses.**	**Contribution Election** **$ _____ pay period / $ _____ plan year**
Limited Purpose FSA - *Select one only; maximum annual contribution is* $3,400.00		
☐ **Waive**	☐ **I elect to enroll in the Limited Purpose FSA to be used for qualified dental and visions expenses.**	**Contribution Election** **$ _____ pay period / $ _____ plan year**

Beneficiary Designation: In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek reimbursement under the terms of the plan. I therefore designate as my beneficiary under the plan:

Beneficiary Name:
Relationship:
Address:

Others Terms and Conditions: I understand that I cannot change or revoke this compensation redirection agreement at any time during the plan year unless I experience a qualifying event (including marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse or such other events as the plan administrator determines will permit a change or revocation of an election). The plan administrator may reduce or cancel my compensation redirection or otherwise modify this agreement in the event it is advisable to satisfy certain provisions of the Internal Revenue Code. The authorized redirection of my cash compensation under this agreement shall be in addition to any redirection under other agreements or benefit plans. Any remaining account balances following the end of my plan's designated grace period will be forfeited. By participating in one of the plan options defined above, I acknowledge my Social Security benefits may be slightly reduced.

_____ _____

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