FSA Administration

HEALTH CARE AND/OR DEPENDENT CARE FSA ENROLLMENT

GENERAL INFORMATION

Employer					
Plan Year		Payroll Effective Date	/ /		
Employee Name					
Date of Birth	/ /	Social Security Number	- -		
Home Address					
City		State		Zip Code	
Phone		Email*			

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

HEALTH CARE FSA: Maximum Annual Contribution is $2,850.

☐ **Waive**	☐ **I elect to enroll in the Health Care FSA for medical, vision and/or dental expenses**	**Contribution Election** **$ pay period /$ plan year**

DEPENDENT CARE FSA (Daycare Reimbursement): $5,000 Plan Year Maximum; $2,500 for married filing separately.

☐ **Waive**	☐ **I elect to enroll in the Dependent Care FSA to be used for qualified dependent care 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

Name		Relationship			
Address					
City		State		Zip Code	

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.

Name		Date	/ /
Signature			