

# FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM



Name		Empl ID#		
Address	City	State	Zip	Daytime Phone (   )

**The University's Plan Year begins on July 1 and runs through the following June 30**

A flexible spending account ("FSA") allows employees to be reimbursed with pre-tax dollars for qualifying out-of-pocket health care expenses for you and your eligible dependents and/or dependent day care expenses. New employees and employees who are transferring from a non-benefit eligible position to a benefit-eligible position may make an election within 3 months of their hire/transfer date or must wait until the next annual open enrollment period. Only qualified expenses incurred after the beginning of the Plan Year or the date a newly eligible employee submits his/her enrollment form (whichever is later), through the end of the Plan Year or the date the employee terminates participation in the Plan (whichever is earlier), are eligible for reimbursement. Employees may only enroll, change or cancel elections during the Plan Year if they experience a qualified status change event consistent with the requested change. **Eligible changes to an FSA election must be requested within three months of the date of the status change event or prior to the end of the Plan Year (June 30), whichever occurs first.**

<p><b>HEALTH FLEXIBLE SPENDING ACCOUNT</b></p> <p>I elect an annual deferral of \$ <input type="text"/></p> <p>to the Health FSA on a pre-tax basis (minimum of \$5 per paycheck/maximum of \$6,000 per Plan Year) to be divided equally among the paychecks I receive during the remainder of the Plan Year.</p> <p><i>Eligible medical expenses are those incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease or to affect any structure or function of the body.</i></p> <p><i>You may request reimbursement for eligible medical expenses incurred on behalf of yourself, your spouse, and your dependent children.</i></p>	<p><b>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT</b></p> <p>I elect an annual deferral of \$ <input type="text"/></p> <p>to the Dependent Care FSA on a pre-tax basis (minimum of \$5 per paycheck/maximum of \$5,000 per Plan Year) to be divided equally among the paychecks I receive during the remainder of the Plan Year.</p> <p><i>The Internal Revenue Code limits the amount you may defer to a Dependent Care FSA to \$5,000 per calendar year per family.</i></p> <p><i>Expenses are eligible if they are necessary in order to allow you to work and are for the care of: (a) your child or children age 12 or younger; (b) your spouse who is physically or mentally incapable of caring for himself or herself and resides with you for more than one-half of the calendar year; or (c) your other dependent (e.g., your parent or child age 13 or older), who is physically or mentally incapable of caring for himself or herself, resides with you for more than one-half of the calendar year, and is/could be your tax dependent.</i></p>
---	--

To estimate your per paycheck amount, complete the worksheet on the back of this form.

**I understand and authorize the following:**

- ◆ I elect the benefits indicated above and authorize the appropriate payroll deferrals.
- ◆ I cannot change my election during the Plan Year unless I experience a qualified status change event and request the change within three months of the event date or prior to the end of the Plan Year, whichever is earlier.
- ◆ To be eligible, expenses must not be paid, reimbursed, or reimbursable from any other source.
- ◆ I forfeit any amounts left in my Health FSA and/or Dependent Care FSA after all eligible expenses are submitted for reimbursement. **(Eligible expenses must be submitted no later than September 30 following the end of the Plan Year.)**
- ◆ If I terminate my employment or transfer to a position not eligible to participate in this benefit, only eligible expenses incurred prior to that date will be reimbursed. I may, however, elect to continue participation through COBRA.
- ◆ I must reenroll during open enrollment each year to participate in this benefit during the next Plan Year.
- ◆ I am responsible to keep and submit all receipts to ASI Flex for reimbursement of unreimbursed health and/or dependent care expenses. If I use my Flex Funds Debit Card for Health FSA purchases, I will not need to submit my receipt to ASI Flex unless asked to verify that the expense was an eligible expense.
- ◆ I agree to use my Flex Funds Debit Card for eligible Health FSA expenses that have not already been reimbursed and will not seek reimbursement of those expenses from any other source.

I have read and understand the above information. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize the payroll deductions of amounts elected for the Plan Year.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>Benefit Dept. Use Only</b>	<b>Entry Date:</b>	<b>Entered By:</b>	<b>QC By:</b>	<b>QC Date:</b>
-------------------------------	--------------------	--------------------	---------------	-----------------

To **estimate** your per paycheck deduction, complete the following worksheet. For information or assistance, contact the Benefits Department at 581-7447.

	<b>Health FSA</b>	<b>Dependent Care FSA</b>
Annual Election	\$ _____	\$ _____
Number of Pay Periods Remaining in Plan Year	÷ _____	÷ _____
Per Paycheck Deduction	\$ _____	\$ _____

**IMPORTANT!**

The per paycheck amount is only an *estimate*. The actual amount will depend on the pay period in which your enrollment is entered into the payroll system.

For details on eligible expenses, reimbursement request forms, and other FSA information, see ASI Flex's website at [www.asiflex.com](http://www.asiflex.com).