Flexible Spending Account Agreement Form

Print clearly and return this completed Agreement to Human Resources/Benefits Dept.

Employer Name			
Name (Last, First, MI)		**Social Security Number or ID Number**	
Street Address	**City**	**State**	**ZIP Code**
Effective Date of Election	**Type of Election**		**Date of Birth-MM/DD/YY**
	New Hire Election		

Health Care Flexible Spending Account (FSA) Election – Medical, dental, vision, hearing care expenses		
Qualified expenses include medical, dental, vision, and hearing expenses **for you & your tax dependents** that are not reimbursed under any other source.		
Plan Year Salary Reduction Amount (Maximum as described in your employer Plan)	Per Pay Period $_____	Plan Year Election $_____

Dependent Care Flexible Spending Account (DCFSA) Election - Child/elder daycare expenses		
Qualified expenses are those incurred primarily for the protection and well-being of a child or elder dependent while you work. **DO NOT include medical expenses for your dependents in the DCFSA election. Include these expenses in your election for the Health Care FSA program below.**		
Plan Year Salary Reduction Amount (Maximum $5,000 per calendar year; $2,500 if married and filing separate income tax returns)	Per Pay Period $_____	Plan Year Election $_____

Claim reimbursement is sent directly to a bank account of your choice, and you will be notified by email/text alert each time reimbursement is issued.

Note: If you have previously signed up for this option and do not wish to change the information ASIFlex has on file from a previous year, there is no need to complete the following section.

☐ Please use account information below to set up direct deposit to my bank account and send email/text alerts of my account activity. Attach a voided check or copy of a check to this form. Note: Standard text message charges may apply from your wireless provider.

Name of Financial Institution/Bank _____ Bank Routing Number (9-digit) _____

Account number _____ Type of Account: ☐ Checking ☐ Savings

Email **(required to receive FSA card)**: _____

Cell Phone: _____ Mobile Carrier: _____

☐ Mail a check to my home address. ASIFlex and your employer are not responsible for lost or delayed mail.

I understand:

- I have elected to have pretax deductions from my pay based on the number of pay periods as set up by my employer during the plan year, and that this election will continue until this Agreement is amended or terminated as allowed under the Plan.
- Pretax deductions reduce my compensation for tax purposes which reduces my Social Security benefits.
- I cannot change or terminate my election unless I experience a qualified change in status as allowed under the Plan.
- My employer may change my election if necessary in order to satisfy certain provisions of the Internal Revenue Code.
- My election and this Agreement will cease upon termination of employment.
- Complete claims with correct supporting documentation must be submitted timely as described in the Plan in order to be considered for reimbursement.
- Expenses for which I claim a tax deduction under my income tax return cannot also be reimbursed under this Plan.
- Unused funds are forfeited at the end of the Plan Year or as otherwise defined in the Plan.
- The Dependent Care FSA and Health Care FSA benefits, and my rights and obligations under this plan, as specified in my employer's Plan materials.
- This Agreement cancels any prior election agreement I have made under the Plan and cannot be changed except as stated in my employer's Plan.

Employee Signature _____ **Date** _____

FOR OFFICE USE ONLY

Date received: _____ TAMS ID: _____ Effective Date: _____ Rev. 09_2015

Dept Number: _____ Total Amt Per Pay Period: _____ Other: _____