Enrollment Agreement

I wish to have my salary redirected for the period _______________through _________________in each of the categories below. I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. This agreement is subject to the terms of the City of Flagstaff.

Social Security Number _______/______/_________

Name ___________________________________________ ______________________________________

(Last, First MI)

Street ___________________________________________

City ___________________________________________

State, Zip

| | Per Pay Period | # of Pay Periods | Total for the Plan Year | Not to Exceed |
|---|---|---|---|---|
| **General Purpose** | | | | |
| Health Care Reimbursement Account | _________ | __ | _________ | $5,000.00 |
| Dependent Care Assistance Account | _________ | __ | _________ | $5,000.00 |
| ***Limited Purpose** | | | | |
| Health Care Reimbursement Account | _________ | __ | _________ | $5,000.00 |
| **HDHP Participants only** | | | | |
| Employer Contribution Only | _________ | __ | _________ | $ 529.44 |

* Combined employer and employee contribution cannot exceed $5000 for general and limited purpose accounts for participants of HDHP.

DIRECT DEPOSIT REIMBURSEMENT (Flexible Spending Accounts only)

I authorize ASI to credit my_______________(checking, savings) account number _________________________________ at (name of bank) ____________________________________________________, with my Flexible Spending Account payments. Please attach a copy of a check or a void check and write the bank's routing number _ _ _ _ _ _ _ _ _.

E-MAIL

_____ I wish to receive my notification of direct deposit reimbursement via e-mail over the Internet at the address below instead of U.S. Mail.

E-mail address: ______________________________________________________________________________________

Employee's signature: _________________________________________________ Date ______________

1-800-659-3035
http://www.asiflex.com