



City of Flagstaff Flexible Spending Account Enrollment Form

You must complete this form to start a tax-free account.

Name (Last, First, MI)		Social Security Number	
Mailing Address		City	State
			ZIP Code
Daytime Phone	Home Phone		Enrollment Status
			<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire

Health Care Flexible Spending Account (FSA) Enrollment – For health care expenses				
Qualified expenses include medical, dental, vision and hearing expenses for you and your tax dependents . Include only your expenses after reimbursement from insurance plans in this election.				
Annual Salary Reduction Amount (Annual Maximum of \$3,000) *Health Ins. Plan Selected _____	Limited Scope (For HDHP Plans) _____	Employee Per Pay Period \$ _____	Employer Per Pay Period \$ _____	Annual Election \$ _____

Dependent Care Assistance Program (DCAP) Enrollment – for child/elder daycare expenses		
Qualified expenses include charges for the care and well-being of a child or elder dependent while you work.		
DO NOT include medical expenses for your dependents in the DCAP enrollment section. Please include these expenses in your enrollment for the Health Care FSA program above.		
Annual Salary Reduction Amount (Cannot exceed \$5,000, or \$2,500 if married and filing separate income tax returns)	Per Pay Period \$ _____	Annual Election \$ _____

How do you prefer ASIFlex to reimburse you for your FSA claims? (select either Direct Deposit or Check)

If you have previously signed up for direct deposit, and do not wish to change the banking information ASIFlex has on file from a previous year, there is no need to complete the banking information portion of this form.

Please use account information below to set up direct deposit (attach a voided check or copy of a check to this form)

Name of bank _____ 9-digit bank routing number _____ Account number _____

This is a checking account or savings account

If you choose to have your reimbursements deposited into your checking or savings account, how do you prefer ASIFlex to notify you of the deposit?

Notify me by e-mail. My e-mail address is _____ **OR** Mail the notice to my home address.

Check: If you choose to receive reimbursement by check, select this box. Mail a check to my home address.

I understand:

- I have requested tax-free paycheck deductions based on the number of paychecks I expect to receive in the 2011/2012 plan year. If enrolling during open enrollment, these deductions will start with my first paycheck in the 2011/2012 plan year. If enrolling in the 2011/2012 plan year, these deductions will start with the first paycheck of the month after this form is submitted and approved, through the plan year.
- The DCAP and FSA benefits, and my rights and obligations under this plan, as specified in the *Flexible Spending Account Enrollment Guide*.
- This form cancels any prior elections I have made under this plan, and cannot be changed except as stated in the *Flexible Spending Account Enrollment Guide*.
- Elections during open enrollment are effective July 1, 2011 and are **collected equally from each paycheck** I will receive throughout the 2011/2012 plan year, or during my initial contracted period of employment with my employer.

Employee signature _____

Date _____

Please return this form to Human Resources for processing.

Questions? Call ASIFlex toll-free at 1-800-659-3035 (TTY 1-866-908-6043) or send an e-mail to asi@asiflex.com