



Flexible Spending Account Enrollment Form

You must complete this form to start a tax-free account for either or both programs.

Form with fields for Name (Last, First, MI), Social Security Number, Street Address, City, State, ZIP Code, Daytime Phone, Home Phone, and Enrollment Status (Open Enrollment, New Hire).

Dependent Care Assistance Program (DCAP) Enrollment -- For child/elder daycare expenses. Includes text: 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 below. Fields for Annual Salary Reduction Amount, Per Pay Period, and Annual Election.

Health Care Flexible Spending Account (FSA) Enrollment -- For health care expenses. Includes text: Qualified expenses include medical, dental, vision, and hearing expenses for you & your tax dependents. Include only your expenses after reimbursement from insurance plans in this election. Fields for Annual Salary Reduction Amount, Per Pay Period, and Annual Election.

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

Direct Deposit: If you choose to receive reimbursement by direct deposit, select one of these two options:

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 2009/2010 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, 2009 and are collected equally from each paycheck I will receive throughout the 2009/2010 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