Benefit Options
Choice Value Health

ADOA-HRD
Human Resources

STATE OF ARIZONA
LIMITED FLEXIBLE SPENDING ACCOUNTS
2015 OPEN ENROLLMENT FORM

☐ **NEW EMPLOYEE**	☐ **TERMINATION**	☐ **SPECIAL ENROLLMENT**	☐ **QUALIFIED LIFE EVENT**

PROCESS LEVEL	EFFECTIVE DATE	RK REQUIRED

DO NOT WRITE ABOVE THIS LINE - FOR AGENCY USE ONLY

EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	EMPLOYEE ID NUMBER (EIN)	
CITY, STATE, ZIP CODE	COUNTY OF RESIDENCE	DATE OF BIRTH

I hereby authorize and direct my employer to reduce my salary by the amount indicated below. Such a reduction, considered as an elective contribution under the State of Arizona Benefit Options Program, shall start with my first check on or after the effective date and will be taken from each check throughout the PLAN YEAR (All Plan Years are 12-month periods starting on January 1). The first payroll deduction occurs the first payday in January, 2015.

Medical Flexible Spending Account (DENTAL AND VISION ONLY)

The amount I elect to have deducted each pay period for Dental and Vision Reimbursement (minimum of $5.00). The Plan Year maximum is **$2,550**.

Period Amount $_____ x 26 or remaining pay periods = $_____ Annual Amount

Dependent Care Flexible Spending Account

The amount I elect to have deducted each pay period for Dependent Care Reimbursement (minimum of $10.00). The Plan Year maximum is **$5,000**.

Amount $_____ x 26 or remaining pay periods = $_____ Annual Amount

I understand that my election made herein is irrevocable, but may be changed only as of January 1 of each year or in the event of a qualifying life event (e.g., marriage, divorce, death of a spouse or dependent, birth or adoption of a child or a child placed by court order in the employee's household, change in the status of a dependent or a change in spouse's employment). Increases/decreases are allowed mid-year for eligible dependent care for life event changes. **For dental and vision reimbursement, only increases are allowed for life event changes; no mid-year decreases are permitted.** The requested change must be submitted within 31 days of the life event to the Agency Benefits Liaison. Furthermore, I am aware that any expenses claimed cannot be claimed on my Federal or State income tax returns.

AUTHORIZATION: I understand that the plan year runs from January 1, or effective date of enrollment, through December 31 for Dependent Care FSA and January 1, or the effective date of enrollment, through December 31 for Limited Medical Care FSA and those eligible expenses must be incurred during this period. I am aware that claims for eligible expenses must be submitted by March 31, 2016 for reimbursement**. If claims for eligible expenses are not submitted by March 31, 2016, any remaining balance in your account(s) will be forfeited.**

DIRECT DEPOSIT REIMBURSEMENT (optional)

See www.asiflex.com website for information

EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/dependent information is accurate. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702 and other applicable provisions of the law. I authorize my employer to reduce my salary by applicable pre-tax dollars or reduce my paycheck by the applicable after-tax dollars for the insurance programs which I have elected.

EMPLOYEE SIGNATURE:_____ DATE:_____

THE REIMBURSEMENT PROCESS

• A claim will be paid by ASI the next day following receipt by ASI, PROVIDED all required documentation is attached to the claim.
• When you have an expense that qualifies for inclusion in a reimbursement account, you submit a Claim Form and a copy of the itemized bill or statement of services
• You cannot be reimbursed more than your annual election amount.

HOW TO FILE A CLAIM

• You must submit an itemized bill or statement from the medical or dependent care service provider. Medical insurance premiums which you pay outside the State payroll system are NOT eligible for reimbursement. These documents must show: 1) date of service, 2) description of and charge for the service, 3) provider's name, and 4) name of the family member for whom the medical service or dependent care was provided.
• For dependent care reimbursement, your claim submission must include the tax identification number (or social security number) of the provider. Please refer to www.asiflex.com for a complete definition of "qualifying person".
• IRS regards the date of the expense as being when the service is rendered, not when you actually pay the bill.
• Expenses may not be submitted until the services are performed.
• Please be sure to sign and date each claim form submitted. If you do not, your reimbursement cannot be processed. Include a copy of itemized bills or statements from the provider(s).
• Claims may be submitted by mail, fax or electronically. The fax number is 1.877.879.9038. Detailed instructions for submitting claims can be found on the back of the claim form or at www.asiflex.com.
• The plan year runs from January 1, or effective date of enrollment, through December 31 for Dependent Care FSA and January 1, or the effective date of enrollment through December 31 for Health Care FSA. Eligible expenses must be incurred during this period. Claims for Dependent Care and Medical expenses must be submitted by March 31, 2016 for reimbursement. **If claims for expenses are not postmarked by the deadline, any remaining balance in your account(s) will be forfeited.**

EMPLOYEE REPORTS

• Each reimbursement will have an account summary on the check stub or direct deposit statement.
• Every quarter, you will receive a statement reflecting the status of your reimbursement account.
• You will receive a statement thirty (30) days prior to the end of the plan year.

EMPLOYEE TERMINATION

When an employee terminates his/her employment with the state, his/her FSA also terminates. The last day to incur expenses is the last day of the coverage period for which the employee had an FSA deduction.

COBRA COVERAGE AND PAYMENT

An employee may be eligible to continue FSA participation through the COBRA program. Employees may obtain a COBRA enrollment form from their agency human resources office. If approved for COBRA coverage, the employee should send their FSA payment directly to the Arizona Department of Administration, HITF – MSD. ATTN: FSA payment, 100 N. 15th Avenue, Suite #103, Phoenix, Arizona 85007-2629. NOTE: If an employee chooses to continue his/her FSA through COBRA coverage, the FSA payment is no longer made on a pre-tax basis and a 2% COBRA administrative fee will be assessed.

CLAIM FORMS

If you need additional Claim Forms, contact your Agency Benefit Liaison or ASI. You may also download a Claim Form from www.asiflex.com.

ASI CONTACT INFORMATION

If you have any questions about your account balance, payment distribution, or claims status, call ASI at (800) 659-3035 for any other questions. **This document is not a complete description of the ASI program**. Please refer to www.asiflex.com for a comprehensive description of the program and eligible expenses.