ARIZONA
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) 2022

For use with the Triple Choice Plan (TCP)

SECTION 1: EMPLOYEE INFORMATION

LAST NAME			FIRST NAME		M.I.
EMPLOYEE ID NUMBER (EIN)	SOCIAL SECURITY NUMBER (SSN)	BIRTH DATE	❑ FEMALE ❑ MALE	❑ SINGLE ❑ MARRIED	❑ NEW EMPLOYEE ❑ TERMINATION ❑ SPECIAL ENROLLMENT ❑ QUALIFIED LIFE EVENT
MAILING ADDRESS	CITY	ST	ZIP	COUNTY	
HOME PHONE	CELL PHONE	EMAIL: PERSONAL ADDRESS ONLY, PROVIDED TO VENDOR TO CREATE YOUR ACCOUNT ON TASCONLINE.COM			

SECTION 2: CALCULATE YOUR FSA AMOUNT PER PAY PERIOD

- Health Care FSAs are for medical, dental and vision expenses.
- Choose your Total Annual Contribution for 2022 for Health Care Flexible Spending Account (FSA). For limits, see Section 3.
- Divide by how many pay periods are left in the year.
- Total equals your Contribution Amount per Pay Period. Use this information to fill out Section 3.
  - Example: Total Annual Contribution $2,000 ÷ 15 Pay Periods = $133.33 Contribution Per Pay Period
  - See a pay period calendar on benefitoptions.az.gov/payrollcalendar
- Deductions for FSA contributions are taken on a pre-tax basis. This reduces your taxable income.

SECTION 3: HEALTH CARE FSA

Health Care FSA Limits for the 2022 Plan Year (1/1/2022 - 12/31/2022)

- $2,750 - single or married filing jointly, minimum contribution: $130 per year

Total Health Care FSA Contribution Amount for the Plan Year 2022 $_____ ÷ ____ Remaining Pay Periods = $____Contribution Per Pay Period

Change takes effect the pay period after form is submitted. See a pay period calendar on benefitoptions.az.gov/payrollcalendar

INITIAL	
x___	**FUND AVAILABILITY: The full annual amount is pre-loaded to your account and accessible the start of the Plan Year or the effective date.**

SECTION 4: ACCESSING FUNDS & REIMBURSEMENT

TASC is the FSA administrator. **Register on tasconline.com** to access funds and submit reimbursements via the TASC app, VISA Debit Card or your online account.

SECTION 5: ACKNOWLEDGEMENTS AND AUTHORIZATIONS

INITIAL	
x___	***ELECTION CHANGES:** I understand elections for the Health Care FSA are irrevocable for the Plan Year: 1/1/2022, or the effective date of enrollment for new hires, through 12/31/2022. Changes may be made only during Open Enrollment or due to a qualifying life event (QLE) (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, or change in the status of a dependent). The requested change must be submitted within 31 days of the QLE to my agency's Benefits Liaison.
x___	**RE-ENROLLMENT REQUIRED ANNUALLY:** I understand my elections do not roll over. If desired, I must re-enroll in my FSA(s) each year.
x___	**ELIGIBLE EXPENSE CLAIMS:** I understand eligible expenses must be incurred during the Plan Year: 1/1/2022, or the effective date of enrollment for new hires, through 12/31/2022. I understand claims for eligible expenses must be submitted for reimbursement with the required supporting documentation by 3/31/2023. If claims for eligible expenses are not submitted by 3/31/2023, any remaining balance in my account(s) will be forfeited. For a list of eligible expenses, visit benefitoptions.az.gov/employee/fsa. I understand eligible expenses claimed on an FSA cannot also be claimed on my Federal and/or State tax returns.
x___	**PAYROLL DEDUCTIONS:** I hereby authorize my employer to reduce my salary by the amount(s) indicated in Section 3. Elective contribution(s) under the State of Arizona Benefit Options Program will start with my first paycheck on or after the effective date and will be taken from each check throughout the Plan Year: 1/1/2022, or the effective date of enrollment, through 12/31/2022. The first payroll deduction occurs the first payday of 2022, or *the pay period after form is submitted.* I hereby certify under penalty of perjury that the information I have provided in this application for employee benefits, including address, personal email, and contact information, is accurate. I acknowledge 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.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

RETURN TO: ADOA HR-BENEFITS, 1802 W. Jackson St. #94, Phoenix, AZ 85007
BENEFITS@AZDOA.GOV | PHONE: 602-542-5008 | TOLL-FREE: 1-800-304-3687 | FAX: 602-542-4744 | BENEFITOPTIONS.AZ.GOV

ADOA USE | PROCESS LEVEL: _____ **EFFECTIVE DATE:** ___/___/___ **RK REQUIRED:** _____