ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) 2024

For use with the Triple Choice Plan (TCP)

SECTION 1: EMPLOYEE INFORMATION

LAST NAME			FIRST NAME		M.I.
EMPLOYEE ID (EIN)	SOCIAL SECURITY (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	PERSONAL EMAIL 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 this 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 2024 Plan Year (1/1 - 12/31/2024)

- $3,050 - single or married filing jointly, minimum contribution: $130 per year

Total FSA Contribution Amount for the Plan Year 2024 $_____ ÷ _____ 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	
	FUND AVAILABILITY: The full annual amount is pre-loaded to your account at the start of the Plan Year or the effective date.

SECTION 4: ACCESSING FUNDS & REIMBURSEMENT

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

SECTION 5: ACKNOWLEDGEMENTS AND AUTHORIZATIONS

INITIAL	
INITIAL	**ELECTION CHANGES -** I understand the following: Elections for the Health Care FSA are irrevocable for the Plan Year: 1/1/2024, or the effective date of enrollment for new hires, through 12/31/2024. 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.
INITIAL	**RE-ENROLLMENT REQUIRED ANNUALLY -** I understand my elections do not roll over. If desired, I must **re-enroll** in my FSA(s) each year.
INITIAL	**ELIGIBLE EXPENSE CLAIMS -** I understand the following: eligible expenses must be incurred during the Plan Year: 1/1/2024, or the effective date of enrollment for new hires, through 12/31/2024. Claims for eligible expenses must be submitted for reimbursement with the required supporting documentation by 3/31/2025. If claims for eligible expenses are not submitted by 3/31/2025, any remaining balance in my account(s) will be forfeited. For an eligible expense list, see irs.gov/pub/irs-pdf/p969.pdf. Eligible expenses claimed on an FSA cannot also be claimed on Federal and/or State taxes.
INITIAL	**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: 1/1/2024, or the effective date of enrollment, through 12/31/2024. The first payroll deduction occurs the first payday of 2024, 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: ARIZONA DEPARTMENT OF ADMINISTRATION, BENEFITS, 1802 W JACKSON ST, #94, PHOENIX, AZ 85007
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