

SECTION 1: EMPLOYEE INFORMATION

LAST NAME			FIRST NAME			M.I.
EMPLOYEE ID NUMBER (EIN)	SOCIAL SECURITY NUMBER	BIRTH DATE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> NEW EMPLOYEE <input type="checkbox"/> TERMINATION <input type="checkbox"/> SPECIAL ENROLLMENT <input type="checkbox"/> QUALIFIED LIFE EVENT	
MAILING ADDRESS		CITY	ST	ZIP	COUNTY	
HOME PHONE	CELL PHONE	PERSONAL ADDRESS ONLY: VENDOR CREATES YOUR TASC.ONLINE.COM ACCOUNT				

SECTION 2: CALCULATE YOUR LIMITED PURPOSE FSA AMOUNT PER PAY PERIOD

- Limited Purpose Health Care FSAs are for dental and vision expenses. Enrollment in the HDHP w/HSA is required.
- Choose your Total Annual Contribution for Limited Purpose Health Care 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: LIMITED PURPOSE HEALTH CARE FSA

Limited Purpose Health Care FSA Limit for the 2023 Plan Year (1/1/2023 – 12/31/2023)

- \$2,750 – single or married filing jointly, minimum contribution: \$130 per year
- Total FSA Contribution Amount for the Plan Year 2023 \$ _____ ÷ _____ 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. Register on tasconline.com to access funds & submit reimbursements via the TASC app, Debit Card or online account.

SECTION 5: ACKNOWLEDGEMENTS AND AUTHORIZATIONS

INITIAL *ELECTION CHANGES: I understand elections for the Limited Purpose Health Care FSA are irrevocable for the Plan Year: 1/1/2023, or the effective date of enrollment for new hires, through 12/31/2023. Changes may be made only during Open Enrollment or due to a qualifying life event (QLE). 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 eligible expenses must be incurred during the Plan Year: 1/1/2023, or the effective date of enrollment for new hires, through 12/31/2023. I understand claims for eligible expenses must be submitted for reimbursement with the required supporting documentation by 3/31/2024. If claims for eligible expenses are not submitted by 3/31/2024, 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.

INITIAL PAYROLL DEDUCTIONS: I hereby authorize my employer to reduce my salary by the amount(s) indicated in Section 3. Elective contribution(s) will start with my first paycheck on or after the effective date and will be taken from each check throughout the Plan Year: 1/1/2023, or the effective date of enrollment, through 12/31/2023. The first payroll deduction occurs the first payday of 2023 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 laws.

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