ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) 2024

For use with the High Deductible Health Plan with Health Savings Account (HDHP w/HSA) for Dental & Vision Expenses Only

SECTION 1: EMPLOYEE INFORMATION

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

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

- Limited Purpose Health Care FSAs are for qualified dental and vision expenses only. Enrollment in the HDHP w/HSA is required. Please note you can use your HSA to pay for qualified dental and vision expenses, this FSA is designed to be a supplement.
- 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 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 <u>pre-loaded to your account</u> 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: 1/1/2024, 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, visit irs.gov/pub/irs-pdf/p969.pdf. Eligible expenses claimed on an FSA cannot also be claimed on my 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) 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 laws.

EMPLOYEE SIGNATURE: _____ **DATE:**

RETURN TO: ADOA-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