ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

LIMITED FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT FORM 2020

HDHP with HSA for DENTAL & VISION ONLY | DEPENDENT CARE

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

- Choose your total FSA Contribution Amounts for 2020 for Health Care (eligible Dental and Vision expenses only) and/or Dependent Care.
- Divide by 26 pay periods for the full year. (New Hires: divide by how many pay periods are left in the year.) Example: $2,000 ÷ 26 = $76.92
- Total equals your Employee FSA Contribution Amount per Pay Period. Use this information to fill out Section 3 and/or Section 4 below.
- Deductions for FSA contributions are taken on a pre-tax basis. This reduces your taxable income.

SECTION 3: HEALTH CARE FSA – DENTAL AND VISION ONLY

The Health Care FSA Limit is $2,700 for the Plan Year (1/1/2020, or the effective date of enrollment for new hires, through 12/31/2020). Minimum contribution: $5.

Total Health Care FSA Contribution Amount Per Year $_____ ÷ 26 (OR remaining pay periods) = $_____ deducted per pay period.

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

SECTION 4: DEPENDENT CARE FSA

The Dependent Care FSA Limit is $5,000 for the Plan Year (1/1/2020, or the effective date of enrollment for new hires, through 12/31/2020). Minimum contribution: $10.

Total Dependent Care FSA Contribution Amount Per Year $_____ ÷ 26 (OR remaining pay periods) = $_____ deducted per pay period.

INITIAL	
x_____	**FUND AVAILABILITY: The funds are added to your account per pay period. <u>You may only access the amount currently in your account</u>.**

SECTION 5: 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 6: ACKNOWLEDGEMENTS AND AUTHORIZATIONS

INITIAL	
x_____	**ELECTION CHANGES:** I understand elections for a health care and/or dependent care FSA are irrevocable for the Plan Year: 1/1/2020, or the effective date of enrollment for new hires, through 12/31/2020. 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, change in the status of a dependent or a change in spouse's employment). **<u>For a Health Care FSA, only increases are allowed for a QLE; decreases are not permitted for a QLE.</u>** The requested change must be submitted within 31 days of the QLE to the Agency 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: 1/1/2020, or the effective date of enrollment for new hires, through 12/31/2020. I understand claims for eligible expenses must be submitted for reimbursement with the required supporting documentation by 3/31/2021. If claims for eligible expenses are not submitted by 3/31/2021, any remaining balance in my account(s) will be forfeited. For a list of eligible and ineligible 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 Sections 3 and/or 4. 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: 1/1/2020, or the effective date of enrollment, through 12/31/2020. The first payroll deduction occurs the first payday of 2020. 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-BENEFIT SERVICES DIVISION, 100 N. 15TH AVE, STE 260, PHOENIX, AZ 85007
BENEFITSISSUES@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:** _____