Flexible Spending Account Agreement Form

Print clearly and return this completed Agreement to your Human Resources Associate.

Employer Name
State of Iowa

Name (Last, First, MI)	Social Security Number or ID Number

Street Address	City	State	ZIP Code

Effective Date of Election	Type of Election	Date of Birth-MM/DD/YY
	☐ Open Enrollment Election ☑ New Hire Election	

Health Care Flexible Spending Account (FSA) Election – Medical, dental, vision, hearing care expenses

Qualified expenses include medical, dental, vision, and hearing expenses **for you & your tax dependents** that are not reimbursed under any other source.

Plan Year Salary Reduction Amount *Maximum $2,700*	Annual Election $ _____

Dependent Care Flexible Spending Account (DCFSA) Election - Child/elder daycare expenses

Qualified expenses are those incurred primarily for the protection and well-being of a child or elder dependent while you work. **DO NOT include medical expenses for your dependents in the DCFSA election. Include these expenses in your election for the Health Care FSA program below.**

Plan Year Salary Reduction Amount *Maximum $5,000, or $2,500 if married and filing separate income tax returns*	Annual Election $ _____

Claim reimbursement is sent directly to a bank account of your choice. You will be notified by email/text alert each time reimbursement is issued.

Note: The State of Iowa encourages direct deposit and email notifications. Please consider using both to *Go Green.* You can change this information at any time during the year.

☐ Please use account information below to set up direct deposit to my bank account and send email/text alerts of my account activity. Attach a voided check or copy of a check to this form. Note: Standard text message charges may apply from your wireless provider.

Name of Financial Institution/Bank _____ Bank Routing Number (9-digit) _____

Account number _____ Type of Account: ☐ Checking ☐ Savings

Email: _____ Cell Phone: _____ Mobile Carrier: _____

☐ Mail a check to my home address. ASIFlex and your employer are not responsible for lost or delayed mail.

I understand:

- I have elected to have pretax deductions from my pay based on the number of pay periods as set up by my employer during the plan year, and that this election will continue until this Agreement is amended or terminated as allowed under the Plan.
- Pretax deductions reduce my compensation for tax purposes which reduces my Social Security benefits.
- I cannot change or terminate my election unless I experience a qualified change in status as allowed under the Plan.
- My employer may change my election if necessary in order to satisfy certain provisions of the Internal Revenue Code.
- My election and this Agreement will cease upon termination of employment.
- Complete claims with correct supporting documentation must be submitted timely as described in the Plan in order to be considered for reimbursement.
- Expenses for which I claim a tax deduction under my income tax return cannot also be reimbursed under this Plan.
- Unused funds are forfeited at the end of the Plan Year as defined in the Plan.
- The Dependent Care FSA and Health Care FSA benefits, and my rights and obligations under this plan, as specified in my employer's Plan materials.
- This Agreement cancels any prior election agreement I have made under the Plan and cannot be changed except as stated in my employer's Plan.

Employee Signature _____ **Date** _____

Reset

Questions? Visit ASIFlex at www.asiflex.com. Email asi@asiflex.com. Call 1-800-659-3035

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