State of Delaware 2019 Plan Year

Flexible Spending Account (FSA)
Enrollment Agreement for January 1 – December 31, 2019

Name (Last, First, MI)		Employee ID Number + Last 4 SSN	
		-	
Street Address	**City**	**State**	**ZIP Code**
Agency/School District Name	**Date of Hire**	**Daytime Phone Number**	

Health Care Flexible Spending Account (FSA) Election – Medical, dental, vision, prescriptions

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

Plan Year Election Amount (Minimum of $50, Maximum of $2,700)	Plan Year Election* $_____	** Your plan year election will be divided by the number of pay dates remaining in the calendar year.*

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 (under age 13) or elder dependent while you work. ***DO NOT include medical, dental, vision or prescription expenses for your dependents in the DCFSA election. Include these expenses in your election for the Health Care FSA program above.***

Plan Year Election Amount (Minimum of $50, Maximum of $5,000)	Plan Year Election* $_____	** Your plan year election will be divided by the number of pay dates remaining in the calendar year.*

Electronic Communications and Direct Deposit Reimbursement Authorization

If you are already signed up and do not wish to make a change, skip this section.

Name of Financial Institution/Bank		Bank Routing Number (9-digit) __ __ __ __ __ __ __ __ __
Account number		Type of Account ☐ Checking ☐ Savings
Email	Cell Phone	Mobile Carrier

☐ Please use account information above 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.

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

I understand:

- **The Health Care FSA and Dependent Care FSA benefits, AND my rights and obligations under this plan, as specified in the "FSA Plan Booklet" located at de.gov/statewidebenefits.**
- **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.**
- **I cannot change or terminate my election UNLESS I experience a qualified change in status as allowed under the Plan.**
- **I will have until April 15th 2020, to submit claims for reimbursement for eligible services received from January 1, 2019 through March 15, 2020. Any unused amounts remaining in my account at the end of this specified period of time will be forfeited.**
- **This request is for the current plan year ONLY and it is my responsibility to enroll to participate in future open enrollment periods for future plan years.**
- **My election and this Agreement will cease upon termination of employment or retirement.**

Employee Signature _____ **Date** _____

Questions? Please contact Statewide Benefits Office, at 1-800-489-8933 or visit de.gov/statewidebenefits.
Return this form to Statewide Benefits Office by fax, (302) 739-8339.