State of Delaware

Flexible Spending Account (FSA) Enrollment Agreement

Plan Year July 1, 2021 – June 30, 2022

Name (Last, First MI)		Employee ID + 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 dependents** that are not reimbursed under any other source.*

Plan Year Election Amount (Minimum of $50, Maximum of $2,750)	Plan Year Election* $_____	**Your plan year election will be divided by the number of pay dates remaining in the plan year.*

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

Qualified expenses include care for the protection and well-being of a child (under age 13) or elder dependent while you work. Examples include before and after school care, child daycare and camps, and elder care.

Plan Year Election Amount (Minimum of $50, Maximum of $10,500)	Plan Year Election* $_____

**Your plan year election will be divided by the number of pay dates remaining in the plan year. If your election is over $5,000 it will be divided into 6-month periods with each period divided by the number of pay dates remaining in the period. Max election for 07/01/21-12/31/21 is $8,000; Max election for 01/01/22-06/30/22 is $2,500.*

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 Booklets 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 **October 15th** following the end of the Plan Year to submit claims for reimbursement for eligible services received during the current Plan Year and accompanying Grace Period. 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

RETURN THIS FORM TO STATEWIDE BENEFITS OFFICE BY FAX, (302)739-8339.
PLEASE CONTACT STATEWIDE BENEFITS OFFICE AT 1-800-489-8933 WITH QUESTIONS.