

Online Enrollment Guide

Flexible Spending Account



YOU MUST ENROLL EACH PLAN YEAR online during Open Enrollment to continue participation in the FSA Program. Elections **DO NOT** rollover to the next plan year automatically. If you do not enroll during Open Enrollment, then you must wait until the next Open Enrollment Period or until a qualifying event occurs that would justify a mid-year election change.

State of Delaware Flexible Spending Account Plan Online Enrollment and Elections

Please enter your Employee Identification Number:

Access the **ASIFlex Online Enrollment Site** by logging into [Employee Self-Service](#) through my.delaware.gov.

Enter your Employee Identification Number (Six-digit Employee ID **PLUS** the last four digits of the Social Security Number).

Click "Continue".

Enter the first three letters of last name and then the initial of first name.

Click "Continue".

Employees may be prompted to enter full first name, last name or re-enter Employee Identification Number (Employee ID plus the last four digits of your social security number) for verification purposes.

State of Delaware Flexible Spending Account Plan Online Enrollment and Elections

Please Enter the first 3 letters of your last name:

Please enter the initial of your first name:

Why doesn't the system recognize my information?

If system does not recognize your information, it may be due to:

- **Did not enter the Employee Identification Number correctly.** It is your 6-digit employee ID, plus the last four digits of your social security number (no dashes or spaces).
- **Did not enter name correctly.** The name provided to ASI is what is entered into PHRST. This will include initials, hyphenations, pre-fixes, suffixes, etc.

Make your selection from the list of available choices below:

- ☒ Flexible Spending Account Elections
- ☐ Mass Transit / Van Pool Elections
- ☐ Parking Elections
- ☐ Log out

Select "Flexible Spending Account Elections".

Click "Continue".

Note: If you wish to make a change to your FSA Open Enrollment elections, you may login and enroll again anytime during Open Enrollment using this procedure. **The last enrollment submitted will be applied to your FSA participation.**

[Health Care Account \(HCFA\)](#)

If you wish to participate:

Select "Health Care Account".

Select either Pay Period or Total for the Plan Year to enter your deductions.

You may then enter either the Pay Period Amount or Annual Amount.

Click "Calculate".

Click "Continue".

*If you **do not** wish to participate:*

Select "Decline".

Click "Continue".

Flexible Spending Account Elections

Health Care Account (Qualified expenses include medical, dental, vision and prescriptions for you and your qualified dependents.)

You may choose to participate in the Health Care Account or you may decline to enroll in this portion of the program:

- ☒ Health Care Account
☐ Decline, I realize I am forfeiting this cost-saving benefit.

Health Care Account
Out-of-pocket medical, dental, vision, hearing expenses not paid by Insurance for you and your qualifying dependents
Minimum Annual Election - \$50.00
Maximum Annual Election - \$3,300.00

- Prescription drug and office visit co-pays
- Coinsurance, deductibles
- X-ray, lab, hospital, doctor expenses
- Mileage to/from healthcare providers
- Over-the-counter healthcare products
- Over-the-counter medicines/drugs
- Vision exams, eyeglasses, prescription sunglasses, over-the-counter reading glasses
- Contact lenses, cleaning solutions, vision correction surgery
- Dental exams, x-rays, fillings, crowns, bridges, dentures, denture adhesives, occlusal guards, orthodontia
- Hearing exams, hearing aids and batteries

Would you like to enter your elections by pay period or total for the plan year?

- ☒ Pay Period
☐ Total for the plan year

Please enter the Pay Period Amount you would like to have deducted. Then click on the Calculate button to have the Annual Amount calculated based on the number of pay periods for the year.

Pay Period Amount	Pay Periods	Annual Amount
\$0.00	X 26	=

Calculate

[Dependent Care Account \(DCFSA\)](#)

If you wish to participate:

Select "Dependent Care Account".

You will be required to confirm the age and number of dependents covered under the Dependent Care FSA when enrolling.

Select either Pay Period or Total for the Plan Year to enter your deductions. You may then enter either the Pay Period Amount or Annual Amount.

Click "Calculate".

Click "Continue".

*If you **do not** wish to participate:*

Select "Decline".

Click "Continue".

Flexible Spending Account Elections

Dependent Care Account (Qualified expenses include care for the protection and well-being of a child (under age 13 or elder dependent while you work.)

You may choose to participate in the Dependent Care Account or you may decline to enroll in this portion of the program:

CAUTION! Do not put money into the Dependent Care Account for healthcare expenses. The Dependent Care Account is for work-related child (dependents under age 13) or adult day care.

- ☒ Dependent Care Account
☐ Decline, I realize I am forfeiting this cost-saving benefit.

Dependent Care Account
Child or adult daycare expenses while you work, look for work, or while your spouse is in full-time school
Note: This is not health care
Minimum Annual Election - \$50.00
Maximum Annual Election - \$5,000.00 (\$2,500.00 if married, filing separate tax returns)

- Work-related child or adult daycare expenses
- Preschool (pre-kindergarten)
- Nursery school
- Before school or after school care
- Day camps
- Adult care for qualifying dependent age 13 or older

Would you like to enter your elections by pay period or total for the plan year?

- ☐ Pay Period
☒ Total for the plan year

Please enter the Annual Amount you would like to have deducted. Then click on the Calculate button to have the Pay Period Amount calculated based on the number of pay periods for the year.

Total for the Plan Year	Pay Periods	Pay Period Amount
\$5,000.00	/ 26	= \$192.31

Calculate

Reimbursement

Note: If you change the information on this page, it will affect your direct deposit for ALL programs administered by ASIFlex.

☒ For rapid and secure reimbursement, to my bank account.

Routing Number:

Account Number:

Account Type:

-- or --

☐ Mail reimbursement check to my home. I understand that some banks may assess a fee to cash checks. I also understand that this reimbursement option is not recommended and that my employer and ASIFlex are not responsible for delayed or lost mail.

If you would like to be notified by text, email, or both, check the option(s) below and fill out the information requested.

☐ Text

☐ Email

Reimbursement

Select preferred method of reimbursement.

Select your preferred notification method (you may select both).

Click "Continue".

Debit Card

Choose **Yes** or **No** to indicate if you wish to receive a debit card. *If you are a current debit card holder, you **MUST** choose yes if you would like your card to be funded for the new plan year.*

Click "Continue".

Debit Card Application for Health Care FSA

Complete the Debit Card Application. Click "Continue".

Debit Card

Your Employer offers a debit card which can be used for eligible expenses.



Would you like to use the ASIFlex Debit Card for the FY26 Plan Year?

For current cardholders, on July 1, 2025 your card will be funded with any money remaining from the FY25 Plan Year (July 1, 2024 - June 30, 2025) plus your allocation for the FY26 Plan Year (July 1, 2025 - June 30, 2026). FY25 Plan Year funds will remain on the card for the duration of the FSA Grace Period. Any expenses you incur from July 1, 2025 through September 15, 2026 will be applied to your FY25 balance first, and any excess will be applied to your FY26 available funds.

☐ Yes If you are a current card holder your existing card will be funded for the new plan year (FY26) and you will continue to use your card. If the card is due to expire a new card set will be sent to you automatically. Please complete the Debit Card Application on the next page to verify your information for the new plan year. If you do not currently possess a debit card a new set of cards will be sent to you. Please complete the Debit Card Application on the next page.

☐ No You do not wish to use a debit card. If you are a current card holder your card(s) will be cancelled for the new plan year (FY26). This action does not affect the current FY25 plan year and grace period.

IMPORTANT: The ASIFlex Debit Card provides a convenient method to pay for out-of-pocket health care expenses. The debit card is **NOT** paperless and **DOES NOT** eliminate paperwork.

Review Before Sending

Review and confirm your elections. (Use "Go Back" to change your enrollment elections. *Do not use the web browser navigation to return to a page, otherwise **ALL** information will be **LOST**. The enrollment will **NOT** be completed.*)

Click "Confirm" to complete your enrollment.

Your Elections Have Been Recorded

Print or save this page for your records as proof of your plan year elections and as a reminder of plan year deadlines.

IMPORTANT: It is highly recommended to print or save this screen for your records. A copy of the confirmation will be **REQUIRED** for any enrollment corrections.

Click "EXIT".

Your Elections Have Been Recorded

PRINT THIS PAGE FOR YOUR RECORDS

Confirmation # A-2016718-26-0414105924

Category	Participate	Per Pay Period Contribution	Annual Contribution
Health Care Account	Yes	\$50.00	\$1,300.00
Dependent Care Account	Yes	\$50.00	\$1,300.00

Reimbursements for Claims

You have elected to receive reimbursements by Check (via US Mail) You have elected NOT to receive a debit card.

FY26 PLAN YEAR DEADLINES	
Plan Year Dates	July 1, 2025 - June 30, 2026
Grace Period (Deadline to incur claims by)	July 1, 2026 - September 15, 2026
Deadline to Submit Claims	October 15, 2026

That's it! Your elections have been recorded. The confirmation number at the top is your indication that your enrollment elections have been received by ASIFlex. It is unnecessary to call to ask if we received it. **We only issue confirmation numbers like the one at the top of your screen for the enrollment elections that we successfully receive.**

For the protection of your privacy, we've made it impossible to retrieve your enrollment elections once you leave this screen. **Print this screen so that you have a record of your enrollment elections!**

Call ASIFlex at (800) 659-3035 if you need assistance with enrollment or have plan questions.