

# Flexible Spending Account (FSA) Enrollment Form - 2008 Plan Year



Employee Name: \_\_\_\_\_ UNID#: \_\_\_\_\_

If you wish to enroll in a Flexible Spending Account (Health FSA and/or Dependent Day Care FSA) for the 2008 Plan Year that runs from **July 1, 2008, through June 30, 2009**, you **MUST**: (a) enroll online at <https://gate.acs.utah.edu> or (b) fill out the information below and submit this form to the Benefits Department on or before Wednesday, **April 30, 2008**. *Flexible Spending Account enrollment does not continue from one plan year to the next; you must re-enroll each year to continue participation.*

Health FSA	Dependent Day Care FSA
<p>A Health FSA will reimburse certain <b>eligible medical expenses</b> incurred during the Plan Year <b>for you and your eligible dependents</b> if they cannot be reimbursed from any other source.</p>	<p>A Dependent Day Care FSA will reimburse costs incurred during the Plan Year for <b>care of your eligible dependents</b>. (See the Benefits Department website at <a href="http://www.hr.utah.edu/ben">www.hr.utah.edu/ben</a> for additional information.)</p>
<ul style="list-style-type: none"> <li>▪ The minimum amount you may elect is <b>\$120</b> per plan year (\$5 per pay period).</li> <li>▪ The maximum amount you may elect is <b>\$6,000</b> per plan year.</li> </ul>	<ul style="list-style-type: none"> <li>▪ The minimum amount you may elect is <b>\$120</b> per plan year (\$5.00 per pay period).</li> <li>▪ The maximum amount you may elect is <b>\$5,000</b> per plan year (the IRS limits this amount to \$5,000 per calendar year per family).</li> </ul>
<p><input type="checkbox"/> I elect to enroll in a Health FSA on a pre-tax basis for the 2008 Plan Year. My election for the Plan Year is:</p> <p>\$ _____</p>	<p><input type="checkbox"/> I elect to enroll in a Dependent Day Care FSA on a pre-tax basis for the 2008 Plan Year. My election for the Plan Year is:</p> <p>\$ _____</p>

**The amount you elect for the 2008 Plan Year will be divided equally among all 24 paychecks received during the Plan Year. Your first FSA deduction will appear on your July 7 paycheck.**

**I understand and authorize the following:**

- I elect the benefit indicated above and authorize the appropriate payroll deferrals.
- I understand I cannot change my election during the Plan Year unless I experience a qualified status change event and request a consistent change within three months of the event date.
- To be eligible, expenses must not be paid, reimbursed, or reimbursable from any other source.
- I forfeit any amounts left in my Health FSA and/or Dependent Day Care FSA after all eligible expenses are submitted for reimbursement. (Eligible expenses must be submitted no later than September 30 following the end of the Plan Year.)
- If I terminate my employment or transfer to a position not eligible to participate in this benefit, only eligible expenses incurred prior to that date will be reimbursed. I may, however, elect to continue participation through COBRA.
- I must reenroll during open enrollment each year to participate in this benefit during the next Plan Year.
- I am responsible to keep and submit copies of all receipts to ASI Flex for reimbursement of unreimbursed health and/or dependent care expenses. If I use my Flex Funds™ debit card for Health FSA purchases, I will not need to submit receipt copies to ASI Flex unless asked to verify that the expense was an eligible expense.
- I agree to use my Flex Funds™ debit card for eligible Health FSA expenses that have not been reimbursed and will not seek reimbursement of those expenses from any other source.

I have read and understand the above information. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize the payroll deductions of amounts elected.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_

*Contact information for clarification/correction of form(s)*

**Submit your completed form to:**  
 Benefits Dept., 420 Wakara Way Ste. 105, SLC, UT 84108  
 Hospital Employee Service Center, A024  
 Park Building, Rm 135  
**OR Fax to:** Benefits Department, (801) 585-7375

**More Information can be obtained at:**  
[www.hr.utah.edu/ben](http://www.hr.utah.edu/ben)  
 Open Enrollment Q&A meetings held during April  
 ASI Flex: 1-800-659-3035  
[www.asiflex.com](http://www.asiflex.com)

***This form must be completed and returned ONLY if you wish to enroll in a Health or Dependent Day Care FSA for the 2008 Plan Year. Please keep a copy of your completed form.***

HR Office Use Only  
 Entered by: \_\_\_\_\_ Date: \_\_\_\_\_  
 QC by: \_\_\_\_\_ Date: \_\_\_\_\_