State of Vermont
Flexible Spending Account Enrollment Form

You must complete this form to start a tax-free account for either or both programs.

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

Street Address	City	State	ZIP Code

Daytime Phone	Home Phone	Enrollment Status
		☐ Open Enrollment ☐ New Enrollee

Health Care Flexible Spending Account Enrollment — For health care expenses

Qualified expenses include medical, dental, vision, and hearing expenses **for you & your tax dependents**. Include only your expenses after reimbursement from insurance plans in this election.
Please note that federal rules require that you submit a prescription in order to claim over-the-counter (OTC) drugs and medications. This does not affect OTC supplies such as Band-aids, contact lens solution, etc.

	Per Pay Period	Annual Election
Annual Salary Reduction Amount (Annual Maximum of $2,550)	$_____	$_____

Dependent Care Flexible Spending Account Enrollment — For child/elder daycare expenses

Qualified expenses include charges for the care and well-being of a child or elder dependent while you work.
DO NOT include medical expenses for your dependents in the DCAP enrollment section. Please include these expenses in your enrollment for the Health Care FSA program above.

	Per Pay Period	Annual Election
Annual Salary Reduction Amount (Cannot exceed $5,000, or $2,500 if married and filing separate income tax returns)	$_____	$_____

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

Note: If you have previously signed up for this option and do not wish to change the information ASIFlex has on file from a previous year, there is no need to complete the following section.

☐ 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** _____

Please return this form to Department of Human Resources, 144 State Street, Montpelier, VT 05620.

Questions? Call ASIFlex toll-free at 1-800-659-3035 (TTY 1-866-908-6043) or send an e-mail to asi@asiflex.com