Print Form Clear Form

ASIFlex

Dependent Care Assistance Program (DCAP) & Washington Flex (Health Care 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	Date of Birth

Street Address	City	State	ZIP Code

Daytime Phone	Home Phone	Agency or Higher-Education Institution Name

Employee I.D. *(Higher Education only)*	Enrollment Status
	☐ Open Enrollment ☐ New Hire ☐ Career Seasonal/Contract Employee

Dependent Care Assistance Program (DCAP) Enrollment -- For child/elder daycare expenses	**Benefits Office Use**
Employees, appointed and elected officials of the State of Washington are eligible to participate in DCAP. 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 Washington Flex program below.**	# of Checks Remaining _____ of _____
Annual Salary Reduction Amount (Cannot exceed $5,000, or $2,500 if married and filing separate income tax returns) $_____	Per Check Amount _____

Washington Flex Flexible Spending Account (FSA) Enrollment For health care expenses for you and your tax dependents	**Benefits Office Use**
PEBB insurance-eligible employees are eligible to participate in the Health Care Flexible Spending account. 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.	# of Checks Remaining _____ of _____
Annual Salary Reduction Amount (Minimum of $240, maximum of $3,600) $_____	Per Check Amount _____

How do you prefer ASIFlex to reimburse you for your claims? (select either Direct Deposit or Check)

Direct Deposit: If you choose to receive reimbursement by direct deposit, select one of these two options:

☐ Please use same account information that is already being used for FSA and/or DCAP reimbursements by ASIFlex; **OR**

☐ Please use account information below to set up direct deposit (attach a voided check or copy of a check to this form)

Name of bank _____ 9-digit bank routing number _____ Account number _____

This is a ☐ checking account or ☐ savings account

If you choose to have your reimbursements deposited into your checking or savings account, how do you prefer ASIFlex to notify you of the deposit?

☐ Notify me by e-mail. My e-mail address is_____ **OR** ☐ Mail the notice to my home address.

Check: If you choose to receive reimbursement by check, select this box. ☐ Mail a check to my home address.

I understand:

- I have requested tax-free paycheck deductions based on the number of paychecks I expect to receive in 2009. If enrolling during open enrollment, these deductions will start with my first paycheck in 2009. If enrolling in 2009, these deductions will start with the first paycheck of the month after this form is submitted and approved, through December 31, 2009.
- The DCAP and FSA benefits, and my rights and obligations under this plan, as specified in the *DCAP Program Summary* and the *Washington Flex Enrollment Guide*.
- This form cancels any prior elections I have made under this plan, and cannot be changed except as stated in the *DCAP Program Summary* and the *Washington Flex Enrollment Guide*.
- Elections during open enrollment are effective January 1, 2009 and are **collected equally from each paycheck** I will receive throughout 2009, or during my initial contracted period of employment with the State of Washington.

Employee signature _____ **Date** _____

Community college employees: Employees must return this form to their benefits office for processing. During open enrollment, fax this form (toll-free) to ASIFlex at 1-866-381-9682 or mail to ASIFlex, P.O. Box 6044, Columbia, MO 65205-6044.

If you work at a state agency, or the University of Washington fax this form (toll-free) to ASI at 1-866-381-9682 or mail to ASIFlex, P.O. Box 6044, Columbia, MO 65205-6044.

All other university employees: Please return this form to your benefits office for processing.

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