



# Enrollment Form

You must complete this form to start a tax-free account for either or both programs. During the annual open enrollment period, we encourage you to enroll online at [www.asiflex.com/pebb](http://www.asiflex.com/pebb) instead of submitting this form.

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			
		<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Career Seasonal/Contract Employee			

<b>Dependent Care Assistance Program (DCAP) Enrollment -- For child/elder daycare expenses</b>		<b>Benefits Office Use</b>	
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. <b>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.</b>			# of Checks Remaining _____ of _____
<b>Annual Salary Reduction Amount</b> (Cannot exceed \$5,000, or \$2,500 if married and filing separate income tax returns)	\$ _____		Per Check Amount _____

<b>Washington Flex Flexible Spending Account (FSA) Enrollment For health care expenses for you and your tax dependents</b>		<b>Benefits Office Use</b>	
<b>PEBB insurance-eligible employees are eligible to participate in the Health Care Flexible Spending account.</b> Qualified expenses include medical, dental, vision, and hearing expenses for you & your tax dependents. Include only your estimated expenses after reimbursement from insurance plans in this election.			# of Checks Remaining _____ of _____
<b>Annual Salary Reduction Amount</b> (Minimum of \$240, maximum of \$2,400)	\$ _____		Per Check Amount _____

**How do you prefer ASI 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 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 ASI 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 2008. If enrolling during open enrollment, these deductions will start with my first paycheck in 2008. If enrolling in 2008, these deductions will start with the first paycheck of the month after this form is submitted and approved, through December 31, 2008.
- 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, 2008 and are **collected equally from each paycheck** you will receive throughout 2008, or during your initial contracted period of employment with the State of Washington.

**Employee signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**State agency, University of Washington, and Eastern Washington University employees:** 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.

**Community college employees:** During open enrollment, fax this form (toll-free) to ASI at 1-866-381-9682 or mail to ASIFlex, P.O. Box 6044, Columbia, MO 65205-6044. Outside of open enrollment, employees must return this form to their 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](mailto:asi@asiflex.com)**