Enrollment Agreement
2015 FSA Plan Year

I wish to have my salary redirected for the period _____ **through June 30, 2015** in each of the categories below. I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. This agreement is subject to the terms of the Nevada System of Higher Education Flexible Spending Account Plan.

Name _____ NSHE Employee ID No: _____
(Last, First MI)

Street _____ Social Security Number: _____

City _____ NSHE-South Pay Org: _____

State, Zip (UNLV, CSN, NSC, UCCSN)

	Monthly Deduction	# of Months Remaining		Total for the Plan Year	Not to Exceed
Health Care Flexible Spending Account Available to those enrolled in the HMO or CDHP PPO-HRA ($25/month minimum for both accounts)	_____	x ____	=	_____	$2,500.00
Limited Purpose Flexible Spending Account Available to those enrolled in the CDHP PPO-HSA For vision or dental expenses only ($25/month minimum for both accounts)	_____	x ____	=	_____	$2,500.00
Dependent Care Flexible Spending Account (Daycare only max $416.66 per month)	_____	x ____	=	_____	$5,000.00

How do you prefer ASIFlex to reimburse you for your claims?

Direct Deposit

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

Bank Name _____ 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.

By signing below, I acknowledge that either or both flexible spending accounts with ASI will cost $3.25 per participant per month. The optional debit card will be $9.00 annual fee to be collected at the beginning of the plan year (or prorated at $0.75 per month) and requires that the ASIFlex card application be completed. (Note: ASIFlex card is not available for Dependent Care or Limited Purpose FSA)

Employee's signature: _____ **Date** _____

For further assistance contact ASIFlex: 1-800-659-3035 email: asi@asiflex.com http://www.asiflex.com

RETURN THIS FORM TO YOUR EMPLOYEE BENEFITS OFFICE FOR PROCESSING

BCS-HR Benefits
4505 S. Maryland Pkwy
Box 451026
LAS VEGAS, NV 89154-1026

OR

FAX: (702) 895-1545

For Benefits Office Use Only:

☐ Monthly or ☐ Semi-monthly Insurance plan selected: ☐ CDHP-PPO ☐ HNHMO or ☐ HTHMO