

FLEXIBLE SPENDING PLAN (FSA) DEBIT CARD REQUEST FORM

Please type or print clearly with ballpoint pen.

The fields in the shaded areas below are required. If any shaded field is left blank, the FSA Debit Card will not be issued.

| | | | | | |
|--|-------------|--|---------------------------------|---|----------------|
| CAMPUS: | | SOCIAL SECURITY NUMBER: | FULL NAME (LAST, FIRST, MIDDLE) | | |
| STREET ADDRESS: | | | CITY: | STATE: | ZIP CODE: |
| DAYTIME PHONE: | HOME PHONE: | E-MAIL ADDRESS: | | | DATE OF BIRTH: |
| CSU HEALTH PLAN ENROLLMENT: I AM ENROLLED IN THE FOLLOWING CALPERS HEALTH PLAN: <input type="checkbox"/> BLUE SHIELD HMO (ACCESS, NETVALUE) <input type="checkbox"/> KAISER PERMANENTE <input type="checkbox"/> PERS CHOICE OR PERS SELECT PPO <input type="checkbox"/> PERSCARE <input type="checkbox"/> PORAC | | CSU DENTAL PLAN ENROLLMENT: I AM ENROLLED IN THE FOLLOWING CSU DENTAL PLAN: <input type="checkbox"/> DELTACARE USA – BASIC <input type="checkbox"/> DELTACARE USA – ENHANCED <input type="checkbox"/> DELTA DENTAL PPO – BASIC <input type="checkbox"/> DELTA DENTAL PPO – ENHANCED LEVEL I <input type="checkbox"/> DELTA DENTAL PPO – ENHANCED LEVEL II | | CSU VISION PLAN ENROLLMENT: <input type="checkbox"/> I AM ENROLLED IN THE CSU VISION PLAN (VSP) | |

- ✓ The FSA Debit Card is optional to you, and is only for Health Care Reimbursement Account (HCRA) Plan participants. If you want to receive an FSA Debit Card (aka "FSA Benny Master® Card"), you have to complete this application. If you do not wish to request the FSA Debit Card, you will access your HCRA funds by filing claims and ASIFlex will reimburse you by direct deposit or check.
- ✓ If you request the FSA Debit Card, a separate, \$1.00 per month administrative fee will be deducted directly from your HCRA account by ASIFlex as a one-time, lump sum amount (i.e., \$12.00 if your enrollment begins in January, and the amount is prorated if enrollment begins after January). Therefore, your annual HCRA election amount will be reduced by an amount equal to or less than \$12.00.
- ✓ Upon receipt of this completed form, two (2) debit cards, both in your name, will be issued on your behalf. The cards will be mailed to your home address approximately two weeks from ASIFlex's processing of this form. There is a \$5.00 charge for additional or replacement cards.
- ✓ **When using the FSA Debit Card, ALWAYS select the "credit" option when you present the card at a merchant or a provider, even though the card is referred to as a "debit card."** There is no PIN number associated with this FSA debit card.
- ✓ It is important to note that there will be times when you will be required to **submit substantiating documentation for some debit card transactions.** ASIFlex will notify you when follow-up documentation (i.e., detailed statement of services, etc.) is required. **If you do not provide the requested documentation in the timeframe stated in your notification, your card will be deactivated.**

I hereby state that the above information is accurate, to the best of my knowledge. Additionally, I certify that the FSA debit card will only be used to purchase eligible medical care-related (i.e., health, dental, vision, etc.) expenses, as defined in Code §213(d) of the Internal Revenue Code and that I will not seek reimbursement from any other source for the expenses paid for with the FSA debit card. I also acknowledge that if I do not provide requested documentation in a timely fashion, my card will be deactivated, in accordance with Federal regulations.

Visit the CSU Systemwide Benefits Portal at: www.calstate.edu/hr/benefitsportal for additional information.

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|----------------------------|-------------------|
| Employee's Signature: ▶ | Date Signed: ▶ |
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The application must be sent directly to ASIFlex. Please fax application to: 1-877-879-9038 or Mail to: ASIFlex, P O Box 6044, Columbia, MO 65205-6044