



Enrollment Agreement
2010 Plan Year

I wish to have my salary redirected for the period _____ through 12-31-2010 in each of the categories below. I understand that a copy of the Summary Plan Description is available at www.asiflex.com. 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 Arizona Board of Regents Cafeteria Plan.

ASU ID # _____

Name _____ Campus _____

Street _____

City _____ State, Zip _____

	<u>Per Pay Period</u>	<u># of Pay Periods (HR Use Only)</u>	<u>Total for the Plan Year</u>	<u>Not to Exceed</u>
<input type="checkbox"/> Healthcare FSA	_____	_____	_____	\$5,000
<input type="checkbox"/> Dependent Care FSA	_____	_____	_____	\$5,000
<u>HSA PARTICIPANTS ONLY</u>				
<input type="checkbox"/> Limited Health FSA (Dental & Vision Expenses Only)	_____	_____	_____	\$5,000
<input type="checkbox"/> I decline to participate in the Flexible Spending Account Plan.				

DIRECT DEPOSIT REIMBURSEMENT (for Flexible Spending Accounts only)

I authorize ASI to credit my checking or savings account number _____ at
(name of bank) _____, with my Flexible Spending
Account reimbursements. Please attach a voided check and write the bank's routing number:

_____.
_____.

E-MAIL

I wish to receive my notification of direct deposit reimbursement over the Internet at the following e-mail
address _____.

Employee Signature: _____ Date: _____

FAX to 480-993-0007