CSU The California State University

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:	CSU DENTAL PLAN ENROLLMENT:
☐ ANTHEM HMO (SELECT, TRADITIONAL) ☐ ANTHEM EPO (DEL NORTE ONLY) ☐ BLUE SHIELD ACCESS+ HMO ☐ WESTERN HEALTH ADVANTAGE ☐ HEALTH NET HMO (SALUD Y MAS, SMARTCARE) ☐ SHARP HMO ☐ KAISER PERMANENTE HMO ☐ PORAC ☐ UNITED HEALTHCARE HMO ☐ PERS CHOICE/PERS SELECT ☐PERSCARE	I AM ENROLLED IN THE FOLLOWING CSU DENTAL PLAN (ALSO INDICATE PLAN LEVEL): ☐ DELTACARE USA: ☐ BASIC ☐ ENHANCED ☐ DELTA DENTAL PPO: ☐ BASIC ☐ ENHANCED I ☐ ENHANCED II

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 "ASIFlex 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. You can adjust your annual HCRA election to include the one-time fee only if your monthly HCRA deduction amount does not exceed $216.66.

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 – three 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, either select the "credit" option when you present the card at a merchant or a provider, or you can use a created PIN. Call 1-866-898-9795 to request a PIN.

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.

PLEASE NOTE: If you use the ASIFlex Card during the FSA Grace Period (January 1 - March 15th) and have funds remaining in your HCRA, card transactions will automatically be applied to available funds from the previous plan year and transactions that exceed your available balance from the previous plan year will have the excess applied to available funds from the new plan year. If you do not choose to re-enroll in the HCRA, your card WILL continue to be active with prior year funds for the entire grace period. For any questions or concerns, please contact ASI at (800) 659-3035 or email your questions to asi@asiflex.com

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.

Employee's Signature: ►	Date Signed: ►

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