Flexible Spending Account Enrollment Form

Employer Name: **City of Somerville**

Phone: 833-232-4673 Fax: 855-370-0670 (15 page max)

Employee Information:

Name:
First/Last

Social Security Number:

Address:

City:

State:

Zip Code:

Date of Birth:
MM/DD/YYYY

Primary Phone:

Email Address:

Email is required to receive important account notifications such as claim confirmations, payment notifications and denial letters.

Flexible Benefit Plan Pre-Tax Elections:

Health Care Reimbursement Account: Eligible health expenses include professional medical expenses incurred by my dependents or myself during the Plan Year for the diagnosis, cure mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.

Per Pay Period Contribution

Number of Pay Periods x

Maximum Election Allowed: $3,050/year Minimum Election Allowed: $100/year

Total Election = $

Dependent Care Assistance Account: Eligible dependent day care expenses are incurred to allow you and your spouse (if applicable) to be gainfully employed. Please remember that the IRS will require you to disclose the Tax ID or Social Security Number of your day care provider(s) when you file your income taxes.

Per Pay Period Contribution

Number of Pay Periods x

Maximum Election Allowed: $5,000/year Minimum Election Allowed: $100/year

Total Election = $

Debit Card:

If you would like debit cards, please select the option to the right. Debit cards come in a set of two and fees may apply. If you want to order additional sets of cards, please log into your online portal.

☐ I want Debit Cards.

Direct Deposit:

For faster reimbursement, sign up for direct deposit through our online portal.

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Signature:

By signing below, I agree to the following terms and conditions. I cannot change this election during the Plan Year unless I have a qualifying change in family status. I must make all of my elections carefully and conservatively. Expenses from Reimbursement Accounts cannot be reimbursed from any other source and must be incurred during the Plan Year. Any money unclaimed from my reimbursement account(s) at the end of the Plan Year will be forfeited to my employer after a run-out period. I will not receive it back. For expenses reimbursed through this account I certify I have not been reimbursed and will not seek reimbursement under any other plan covering health benefits. The IRS requires me to keep documentation of all my expenses claimed and supply them to Benefit Strategies if requested. I have read and understood all of the plan details outlined in my Summary Plan Description.

Employee Signature:
First/Last

Date:
MM/DD/YYYY

Employer Acceptance:
First/Last

Benefit Effective Date: January 1, 2024
MM/DD/YYYY

If this is a mid-year enrollment, please list the first payroll date for deductions.

First Payroll Date:
MM/DD/YYYY