



The Health Care Flexible Spending Account (HCFSA) and the Dependent Care Assistance Program (DeCAP) are divisions of the Office of Labor Relations' Tax-Favored Benefits

PLAN YEAR 2009 ENROLLMENT/CHANGE FORM FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

40 Rector Street, 3rd Floor, New York, NY 10006-1705 (212) 306-7760 TTY: (212) 306-7629 nyc.gov/olr

By signing the Enrollment/Change Form:

- I authorize my Employer to reduce my gross salary before federal income taxes and Social Security (FICA) taxes are calculated by the total amount of the annual salary reduction (Plan Year 2009 contribution amount) indicated on Page 3.
- I understand that contributions to the FSA Program may reduce my Social Security benefits, since Social Security contributions will be based on my adjusted gross salary.
- I authorize the FSA Program to deposit my HCFSA/DeCAP reimbursement directly into my checking or savings account as requested (see Section B4). If this section is left blank, a reimbursement check will be sent to the address on file.

Under HCFSA

- I understand that the amount of salary reduction will continue throughout the Plan Year and cannot be reduced, revoked or terminated for any reason whatsoever.
- I understand that I may enroll in the Program or increase my contribution should I become eligible to participate in this Program or acquire new dependents during mid-year. I understand that I must submit an FSA Enrollment/Change Form and a Qualifying Event Mid-Year Change Form to the Plan Administrator within thirty (30) days after a Qualifying Event in order to enroll and/or add dependents. A Qualifying Event can be marriage, adoption or birth of a child, or commencement of new employment with the City.
- I understand that I will be reimbursed for eligible expenses up to my total annual contribution amount, less the administrative fee and any claims previously reimbursed, regardless of the current balance in my account.
- I understand that any health-care expense defined by the IRS as a non-deductible expense for income tax purposes shall be ineligible for reimbursement. I further understand that although an expense may be deductible for income tax purposes, it may be ineligible for reimbursement under this Program.
- I understand that my personal and claim information will not be released to any other individual unless I complete the Health Insurance Portability and Accountability Act (HIPAA) Protected Health Information (PHI) Authorization (See Section D2).
- I understand that I have the right to revoke my HCFSA HIPAA authorization at any time in writing.

Employees Terminating Employment/Unpaid Leave of Absence

- I understand that my HCFSA dollar amount election **cannot** be reduced during the Plan Year. Should my employment be terminated or should I take an unpaid leave of absence, I agree to pay, in full, the amount elected for Plan Year 2009 for HCFSA. I will complete Sections A, B1, and D1-Boxes A, B and C to indicate my annual contribution amount in a lump-sum payroll deduction or pro-rated from my remaining paychecks. I understand that I must notify the FSA Administrative Office in writing in advance of the employment status change for payroll processing.

Under DeCAP

- I understand that the amount of salary reduction will continue throughout the Plan Year, unless I incur an approved Qualifying Event. I understand that I must submit an FSA Enrollment/Change Form and a Qualifying Event Mid-Year Change Form to the Plan Administrator within thirty (30) days after a Qualifying Event in order for any change to be effective.
- I understand that I will be reimbursed up to the total current balance in my account less the administrative fee. Any amounts requested for reimbursement which exceed the current balance in my account will be carried forward to the next month.
- I understand that if I am married and my spouse is not employed, he/she must be either: a) incapable of self-care or b) a full-time student.
- I understand that I may not receive a benefit for eligible employment-related dependent care expenses incurred by me which is in excess of my Earned Income or the Earned Income of my spouse, if I am married.

Under HCFSA and DeCAP

- I understand that the funds in these FSAs can only be paid out to reimburse eligible medical and/or dependent care expenses actually incurred after the start of my Plan participation and during the Plan Year and HCFSA Grace Period, if applicable.
- I understand that I have the burden of proof to show that each medical and/or dependent care expense is reimbursable under this Plan, as well as eligible and reimbursable under all regulations (including the Internal Revenue Code).
- I understand that, under all circumstances, the Plan Administrator reserves the right to request additional information.
- I understand that the Plan Administrator has, among other powers and duties, the power and duty to interpret the Plan and to resolve ambiguities, inconsistencies, and omissions.
- I understand that if I participate in both the HCFSA and DeCAP Programs, I cannot transfer funds from one account to the other.
- I understand that there is an administrative fee of \$4.00 per month per account.
- **I understand that any amount remaining in these FSAs that is not used during the Plan Year and HCFSA Grace Period, if applicable, will be permanently forfeited by me.**

PLEASE PRINT

Please review the FSA Program brochure and pages 1 and 2 of this form before completing.

Section A

- 1. PROGRAM:** (Check one) HCFSAs and DeCAP DeCAP only HCFSAs only
- 2. ENROLLMENT:** (Check One) Open Enrollment Period (Sept. 22, 2008 - Nov. 14, 2008) Newly Eligible Employee (Dec. 1, 2008 - Nov. 15, 2009) Mid-Year Change(s) (Jan. 1, 2009 - Nov. 15, 2009) Complete Section A3 below.
- 3. MID YEAR CHANGE(S):** Check the sections you wish to change. Please attach a DeCAP and/or HCFSAs Qualifying Event Mid-Year Change Form.
 Name (B1, E) Address (B1, E) Agency Transfer (B1, E) Dependent (B, E) Direct Deposit (B, E)
 DeCAP ONLY - Contribution (B, C, E)
 HCFSAs ONLY - Increase Contribution (B, D, E)
 HCFSAs ONLY - Employees terminating employment must notify the FSA Office 30 days prior to termination date for lump-sum or pro-rated payroll deduction to take effect. Department of Education employees terminating employment in the summer must notify the FSA Office by the third week in May (B1, D1, E).

Section B

1. EMPLOYEE (PARTICIPANT) INFORMATION (ALL SECTIONS MUST BE COMPLETED.)

Last Name:		First Name:		M.I.:	Social Security Number:	
Home Address - Number and Street:		Apt. No.:	City:		State:	Zip Code:
Date of Birth: / /		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Legally Separated				
Agency Name (Not Division): (CUNY and HHC employees please specify name of college or hospital.)			Work Phone Number: ()		Home Phone Number: ()	

2. SPOUSE INFORMATION (PLEASE NOTE: DOMESTIC PARTNERS ARE NOT ELIGIBLE FOR THE FSA PROGRAM.)

Last Name:		First Name:		M.I.:	Social Security Number:	
Date of Birth: / /		Employment Status: * Must provide proper documentation under DeCAP ** Not eligible under DeCAP <input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed* <input type="checkbox"/> Full-Time Student* <input type="checkbox"/> Disabled* <input type="checkbox"/> Unemployed**				
Does your spouse's employer(s) offer a Dependent Care Assistance Program that you take part in? <input type="checkbox"/> No <input type="checkbox"/> Yes						
If Yes, Dollar Amount: \$ _____ Please note: The total combined Plan Year Dollar Amount for you and your spouse cannot exceed \$5,000.						

3. DEPENDENT INFORMATION (LIST ALL YOUR ELIGIBLE DEPENDENTS. CHECK THIS BOX IF ATTACHING AN ADDITIONAL PAGE.)

For HCFSAs: The dependent must be eligible for coverage under your medical plan. For DeCAP: The dependent must be claimed on your income tax return.

Last Name	First Name	Social Security Number	Date of Birth	Age	Relationship to Employee <small>(SPOUSE: S, CHILD UNDER AGE 13: C, CHILD OVER 13 AND UNDER 23: CO, DISABLED CHILD: DC, OTHER: O)</small>

4. DIRECT DEPOSIT (MUST ATTACH VOIDED CHECK) *ABA NUMBER: CHECKING ACCOUNT - THE ABA NUMBER IS THE FIRST NINE (9) NUMBERS PRIOR TO THE ACCOUNT NUMBER AT THE BOTTOM LEFT CORNER OF THE CHECK. SAVINGS ACCOUNT - CONTACT YOUR BANK FOR THE ABA NUMBER, IF NOT KNOWN. **ACCOUNT NUMBER: SEE CHECK, PASSBOOK, OR ACCOUNT STATEMENT FOR ACCOUNT NUMBER.

ACCOUNT TYPE: (CHECK ONLY ONE) <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	PERSON(S) NAMED ON ACCOUNT (PRINT EXACTLY) PERSON 1: PERSON 2:	ABA NUMBER* (MUST BE 9 DIGITS) [][][][][][][][][][] ACCOUNT NUMBER** (PLEASE WRITE)
--	--	---

Attach VOIDED check here.

Section C - Dependent Care Assistance Program (DeCAP)

DeCAP 2009 CONTRIBUTION AMOUNT	Annual Contribution: Minimum \$500 Maximum \$5,000 (The Plan Year is January 1 - December 31, 2009.) (NOTE: If you are married and filing separate income tax returns, the maximum that you may allocate to DeCAP is \$2,500.)
BOX A: PLAN YEAR 2009 DOLLAR AMOUNT <i>Enter whole dollars only</i> \$ _____ DeCAP	BOX B: NUMBER OF PAY PERIODS <input type="checkbox"/> 26 (bi-weekly) or <input type="checkbox"/> _____ <input type="checkbox"/> 52 (weekly) or _____ (during mid-year only) <input type="checkbox"/> 24 (semi-monthly & CUNY senior colleges)
	BOX C: DEDUCTION PER PAY PERIOD \$ _____

Section D - Health Care Flexible Spending Account (HCFSAs)

HCFSAs 2009 CONTRIBUTION AMOUNT	Annual Contribution: Minimum \$260 Maximum \$5,000 (The Plan Year is January 1 - December 31, 2009.)
BOX A: PLAN YEAR 2009 DOLLAR AMOUNT <i>Enter whole dollars only</i> \$ _____ HCFSAs	BOX B: NUMBER OF PAY PERIODS <input type="checkbox"/> 26 (bi-weekly) or <input type="checkbox"/> _____ <input type="checkbox"/> 52 (weekly) or _____ (during mid-year only) <input type="checkbox"/> 24 (semi-monthly & CUNY senior colleges)
	BOX C: DEDUCTION PER PAY PERIOD \$ _____

Section D continued - HCFSA ONLY

2. HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) - PROTECTED HEALTH INFORMATION (PHI) AUTHORIZATION

Acknowledgement and Right to Revoke

I hereby authorize the Tax-Favored Benefits Program to provide and disclose PHI to the individuals listed below unless I indicate otherwise in writing. I understand that this authorization will apply to all subsequent transactions until there is an effective revocation. I understand that I have the right to revoke this authorization at any time by notifying the Tax-Favored Benefits Program in writing at 40 Rector Street, 3rd Floor, New York, NY 10006. I understand that such revocation is only effective after it is received by the Tax-Favored Benefits Program. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when the Plan Year and/or Grace Period, if applicable, ends. My signature below also affirms my understanding of the HIPAA Acknowledgement and Right to Revoke as stated above.

Individuals/Organizations authorized to receive PHI: (Check this box if attaching an additional page.)

Relation to employee: (S) - Self; (SP) - Spouse; (DP) - Domestic Partner; (CO) - Child 18 or Over; (OR) - Organization.

Name (Participant and spouse/dependents/organizations)	Signature	Relation to Employee
1.		Self
2.		
3.		
4.		
5.		
6.		

Section E - AUTHORIZATION AND ANNUAL SALARY REDUCTION AGREEMENT

I have received and read the printed material explaining the HCFSA and/or DeCAP benefits and my choices under these programs. I have also read the Enrollment/Change Form information on Pages 1 and 2 of this form. I understand that by signing and submitting this Enrollment/Change Form, I am making a binding election as to my benefit coverage for the Plan Year that begins January 1, 2009. I authorize my Employer to reduce my gross salary as indicated on this form in order to pay for the benefits I have elected. I understand that my payments will be prorated over each payroll period. I authorize the Tax-Favored Benefits Program to provide any personal information on my behalf related to the Tax-Favored Benefits Program to the individuals or organizations I have listed in Section D2 above.

NOTE: I understand that my HCFSA election **cannot** be reduced, revoked or terminated during the Plan Year. Should my employment be terminated or should I take an unpaid leave of absence, I agree to pay, in full, the amount elected on this form for the Plan Year for HCFSA. My HCFSA and/or DeCAP election can only be changed if I experience a Qualifying Event (See Page 1). I further understand that each account is separate and that DeCAP funds cannot be used for or transferred to HCFSA or vice-versa. I understand that any amount remaining in these FSAs that is not used during the Plan Year and HCFSA Grace Period, if applicable, will be permanently forfeited by me. I understand that only eligible dependents listed on this form are eligible to receive reimbursement.

I hereby authorize the Tax-Favored Benefits Program to deposit my HCFSA/DeCAP reimbursement directly into my checking or savings account as requested. I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules, the Tax-Favored Benefits Program can only reverse the amount of the incorrect direct deposit. I agree that this authorization will remain in effect until I provide to the Tax-Favored Benefits Program a written cancellation to terminate the service. I will notify the Tax-Favored Benefits Program if my bank account or ABA number listed in Section B4 should change.

Employee (Participant) Signature

Date

Return completed form to:

Tax-Favored Benefits Program - FSA 2009
 40 Rector Street, 3rd Floor
 New York, NY 10006-1705

Retain a copy for your records.

Do Not Write In This Area							
	Payroll				Database		Agency Payroll Code:
	Initial	Date	PMS Doc #	Other Payroll	Initial	Date	
DeCAP		/ /				/ /	
HCFSA		/ /				/ /	