The Health Care Flexible Spending Account (HCFSA) Program and the Dependent Care Assistance Program (DeCAP) are divisions of the Office of Labor Relations' Flexible Spending Accounts Program.

PLAN YEAR 2024 ENROLLMENT/CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

nyc.gov/fsa

Print Form

Reset Fields

Please review the FSA Program Brochure on the FSA website, and Pages 3 and 4 of this form before completing.

PROGRAM (CHECK ONE): ❑ HCFSA *or* ❑ DeCAP *or* ❑ HCFSA and DeCAP

❑ **ENROLLMENT PERIOD:** Open Enrollment Period (October 2, 2023 - November 15, 2023) - ***Skip Section C***

❑ **MID-YEAR ENROLLMENT/CHANGE:** (January 1, 2024 - November 11, 2024) **- Please complete all appropriate sections, including Section C for mid-year enrollment.**

❑ **NEWLY ELIGIBLE EMPLOYEE:** Hire date: _____/_____/_____ Benefit effective date, if later than hire date: _____/_____/_____

❑ **CHANGE:** ❑ Name ❑ Address ❑ Agency Transfer ❑ Dependent ❑ Direct Deposit ❑ Annual Contribution

❑ HCFSA ONLY - Continuation of Coverage* to accelerate payroll deductions: Last pay date: _____/_____/_____ Last date at work: _____/_____/_____

* Continuation of Coverage: Please refer to page 3 for detailed information.

SECTION A — *Employee, Spouse and Dependent Information*

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

SOCIAL SECURITY NUMBER	DATE OF BIRTH	FEDERAL MARITAL STATUS
- -	/ /	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Legally Separated

AGENCY NAME (NOT DIVISION): (CUNY - PLEASE SPECIFY NAME OF COLLEGE)

Check here ❑ If you are on a weekly payroll.

LAST NAME	FIRST NAME	M.I.

HOME ADDRESS - NUMBER AND STREET	APT. NO.

CITY	STATE	ZIP CODE

DAYTIME PHONE NUMBER	MOBILE PHONE NUMBER	EMAIL ADDRESS
( ) -	( ) -	

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

SOCIAL SECURITY NUMBER	DATE OF BIRTH	EMPLOYMENT STATUS * Must provide proper documentation under DeCAP ** Not eligible under DeCAP *** Need description of occupation on letterhead stationery; or with no letterhead stationery, notarization is required
- -	/ /	❑ Employed ❑ Self-Employed*** ❑ Full-Time Student* ❑ Disabled* ❑ Unemployed**

LAST NAME	FIRST NAME	M.I.

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

FOR DeCAP: THE DEPENDENT MUST BE CLAIMED ON YOUR INCOME TAX RETURN AND UNDER THE AGE OF 13.

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	RELATIONSHIP TO EMPLOYEE			
					(CHECK ONE)	C	AC	DC
					C - CHILD UNDER AGE 13	C	AC	DC
					AC - CHILD AGE 13 THROUGH AGE 26	C	AC	DC
					DC - DISABLED CHILD	C	AC	DC

SECTION B — *Annual Contribution Amount* (January 1, 2024 - December 31, 2024)*

Health Care Flexible Spending Account	$_____ HCFSA	❑ Initial Annual Contribution: Minimum $260 - Maximum $3,200 ❑ Change Annual Contribution: ❑ Increase

* Your DeCAP and HCFSA annual contribution amount will be prorated over each paycheck. Please note that CUNY and DOE/Q Bank will be prorated over 24 paychecks.

Dependent Care Assistance Program	$_____ DeCAP	❑ Initial Annual Contribution: Minimum $500 - Maximum $5,000 ❑ Change Annual Contribution: ❑ Increase ❑ Decrease or ❑ Terminate (**Note**: If you are married and filing separate income tax returns, the maximum that you may allocate to DeCAP is $2,500.)

Does your spouse's employer offer a DeCAP that you take part in? ❑ No ❑ Yes If Yes, Dollar Amount $_____

The total combined Plan Year dollar amount for you and your spouse cannot exceed $5,000.

Please Sign Section F on Page 2.

Over ⟶

SECTION C — Mid-Year Qualifying Event Enrollment/Change

Please indicate the Qualifying Event incurred and attach appropriate documentation. All Qualifying Events MUST be submitted with appropriate documentation in order to be processed. This change must be consistent with your Qualifying Event and described on Page 3 of this Enrollment/Change Form. You must return this form within 30 days after the Qualifying Event indicated below.

Qualifying Event (Please Write):	Qualifying Event Date: / /

HCFSA and DeCAP - Qualifying Events and Required Documentation

- Marriage - Marriage certificate
- Birth of a child - Birth certificate
- Death of participant - Death certificate
- Adoption of a child - Adoption agreement and employee's tax return showing eligible dependents
- New employee - Letter from employer/agency
- Termination of employment (self) - Letter from employer/agency
- Approved unpaid leave of absence (during Open Enrollment Period) - Letter from employer/agency

DeCAP Only - Qualifying Events and Required Documentation

- Divorce/legal separation/annulment - Divorce, annulment decree/separation agreement
- Death (spouse or dependent) - Death certificate
- Change from FT to PT employment or vice versa-Letter from employer/agency (self, spouse)
- Approved unpaid leave of absence - Letter from employer/agency (self, spouse)
- Termination of employment - Letter from employer (self, spouse)
- Reduction or increase of hours worked - Letter from employer (self, spouse)
- Ineligibility of dependent - Birth certificate or other appropriate documentation

SECTION D — Direct Deposit Information - (MUST ATTACH VOIDED CHECK)

NOTE: If you participated in FSA in Plan Year 2023 and your Direct Deposit Information on file remains the same, you do not need to complete this section for Plan Year 2024.

***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)	Person(s) Named on Account (Please Print Clearly)	ABA Number* (Must be 9 Digits)	Attach VOIDED Check Here
❑ Checking ❑ Savings	Person 1: _____ Person 2: _____	Account Number** (Please Write)	

SECTION E — Authorizations, Annual Salary Reduction Agreement and Certification of Qualifying Event

Authorization and Annual Salary Reduction Agreement

I have 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 3 and 4 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 on January 1, 2024. 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 pro-rated over each payroll period.

NOTE: I understand that my HCFSA election cannot be reduced or revoked for any reason except for termination of employment during the Plan Year, or if I should take an unpaid leave of absence. I agree to pay, in full, the amount elected on this form for the Plan Year for HCFSA, by recalculating the payroll deductions upon returning from unpaid leave. My HCFSA and/or DeCAP election can only be changed if I experience a Qualifying Event (Section C). 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 I am only eligible to receive reimbursement on behalf of my eligible dependents listed on this form.

I understand that I will be terminated from participation in the Program if I cease employment with the City of New York or go on an unpaid leave of absence, unless I elect to participate in the Continuation Coverage for HCFSA.

Direct Deposit Authorization

I hereby authorize the Flexible Spending Accounts 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 Flexible Spending Accounts 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 Flexible Spending Accounts Program a written cancellation to terminate the service. I will notify the Flexible Spending Accounts Program if my bank account numbers listed above should change.

Mid-Year Qualifying Event

This is to certify that I incurred the Qualifying Event indicated in Section C and, therefore, wish to modify my benefits as indicated. I understand that the change(s) in benefits requested must be consistent with the Qualifying Event, and that I must provide approved documentation of all change(s), and that the effective date of the change(s) will be the date the forms are received by the Plan Administrator or the date of my first payroll deduction if I become eligible after the beginning of the Plan Year. The participant has the burden of proof to show that the Qualifying Event is acceptable under the Plan. The Plan Administrator reserves the right to request additional information. The Plan Administrator has, among other duties, the power and duty to interpret the Qualifying Event and to resolve ambiguities, inconsistencies and omissions.

SECTION F — Employee/Participant Signature

SIGNATURE:	DATE: / /

Please submit this form electronically to: *https://nyc-fsa.leapfile.net*
Retain a copy for your records

DO NOT WRITE IN THIS AREA

Payroll				
Program	Initials	Date	PMS DOC#	Other Payroll
HCFSA		/ /		
DeCAP		/ /		

Database	
Initials	Date
	/ /
	/ /

Agency Payroll Code
New York State I.D. Number

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PLAN YEAR 2024 ENROLLMENT/CHANGE FORM
FLEXIBLE SPENDING ACCOUNTS (FSA) PROGRAM

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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 2024 contribution amount) indicated on Page 1.
- 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 D).

Under HCFSA

- I understand that the amount of salary reduction will continue throughout the Plan Year and cannot be reduced or revoked for any reason except for termination of my employment during the Plan Year or if I should take an unpaid leave of absence.
- 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 complete all applicable sections of this form and submit it to the FSA Program 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, commencement of new employment with the City, or employee's return from approved unpaid leave of absence (taken during the Open Enrollment Period) or termination of participant's employment with the City of New York.
- 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 Form.
- I understand that I have the right to revoke my HCFSA HIPAA authorization at any time in writing by emailing the Program through the FSA website at nyc.gov/fsa.

HCFSA Continuation of Coverage - Employees Terminating Employment/Unpaid Leave of Absence

If you terminate your employment with the City of New York or go on an unpaid leave of absence during the Plan Year, you cannot submit any claims for services rendered after your termination date, or effective date of your unpaid leave of absence, unless you elect Continuation of Coverage. You may elect to deduct the remaining balance of your goal amount on a pre-tax basis either by lump-sum or pro-rated payroll deductions with the remaining paychecks, as long as the FSA Program Administrator is able to meet the payroll deadlines for the applicable pay dates. Otherwise, you may continue coverage by submitting payment to the FSA program with post-tax dollars.

- I understand that I will be terminated from participation in the HCFSA Program, unless I elect HCFSA Program Continuation Coverage. In this case, I agree to fund the balance of my HCFSA goal amount for the current Plan Year with either (a) pre-tax dollars deducted from my last paycheck(s) or accelerated for the remaining paychecks prior to leaving City service; or (b) post-tax dollars for the remainder of the current Plan Year.
- I understand that if I elect HCFSA Program Continuation Coverage and would prefer that the balance of my goal amount for the current Plan Year be deducted from my last paycheck(s) or accelerated for the remaining paychecks on a pre-tax basis, I will notify the FSA Program Administrative Office in writing by emailing the Program through the FSA website at nyc.gov/fsa thirty (30) days prior to the date I cease employment, or as soon as possible in order for the FSA Program Administrator to meet payroll deadlines.
- I understand that if I take an unpaid leave of absence, I must notify the FSA Program Administrative Office to recalculate the deduction amount upon my return from the unpaid leave of absence and the FSA Program Administrative Office may also recalculate the deduction amount if necessary as long as it is within the same calendar year and within the payroll cut-off dates.
- I authorize the FSA Program Administrative Office to recalculate any missed HCFSA payroll deduction amounts, if the FSA Program Administrator identifies such missed deductions.

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 complete all applicable sections of this form and submit it to the Plan Administrator within thirty (30) days after a Qualifying Event in order for any change to be effective.

- 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 complete all applicable sections of this form and submit it 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, commencement of new employment with the City, employee's return from approved unpaid leave of absence (taken during the Open Enrollment Period) or termination of participant's employment with the City of New York.
- 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 if I do not experience accurate payroll deductions, it is my responsibility to notify the FSA Program immediately.
- 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 participation in the FSA Program 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 the FSA Program, as well as eligible and reimbursable under all regulations (including the Internal Revenue Code).
- I understand that, under all circumstances, the FSA Program Administrator reserves the right to request additional information.
- I understand that the FSA Program Administrator has, among other powers and duties, the power and duty to interpret the FSA Program and to resolve ambiguities, inconsistencies, and omissions.
- I understand that if I participate in both the HCFSA Program and DeCAP, I cannot transfer funds from one account to the other.
- I understand that there is a maximum 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, Claims Run-Out Period and HCFSA Grace Period, if applicable, will be permanently forfeited by me.**