ebm
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New Hire / Change in Status Form

Flexible Spending Pre-Tax Payroll Reduction Authorization

City of Medford

INSTRUCTIONS: Complete and return form to **HR** **within 30 days** of your Date of Hire or Qualified Event.

PAYROLL Use Only:
First P/R Deduction Date: _____
Per Pay-Period Amount: $ _____

❶ Personal Information:

Participant Name: _____ **Plan Year:** **Date of Hire -or- Date of Qualified Change Event *through 6/30/2027***
(Expenses must be incurred between these dates.)

Mailing Address: _____ **Social Security No.:** _____

City/Town, State _____ **ZIP:** _____ **Date of Birth:** _____

E-Mail: _____ **Daytime Phone:** _____ ☐ personal ☐ work

❷ I work for *(check one)*: ☐ City ☐ Schools → I am paid *(check one)*: ☐ Weekly ☐ Bi-weekly 26 (no lump) ☐ Bi-weekly 26 with lump

❸ Date of Hire or Qualified Change Event: _____

❹ Eligibility Event *(check one)*: ☐ New Hire ☐ Marriage ☐ Divorce ☐ Birth/Adoption ☐ Return from Leave of Absence ☐ Other: _____

❺ New Benefit Elections for REMAINDER of the Plan Year:

☐ **Health Care FSA Account ($3,400 annual maximum)** ..... **Election for Remainder of Plan Year: $ _____**

For qualified non-cosmetic health, dental, and vision expenses for you, your legal spouse (if married), and your eligible dependents (as defined by the IRS) including those named on your tax return and your adult children under age 26. **Rollover option:** Any unspent balance for the plan year—*up to **$680***—can roll over to the next plan year provided you re-enroll in the Health Care FSA for that new plan year. *Benefit card included.*

★ ***The City will contribute $150 to your Health Care FSA election if you enroll for at least $150.***

Ineligibility Notice: If you or your spouse have a Health Savings Account (HSA), you are **not eligible** for the Health Care flex-spending (FSA) plan.

☐ **Dependent Care FSA Account ($7,500 annual max. per family)**..... **Election for Remainder of Plan Year: $ _____**

For qualified day care expenses for your eligible dependents (as defined by the IRS) who are **under age 13**, elderly dependents, and dependents with special needs named on your tax return. For day care, pre-school, before/after-school care, day camp when used as necessary day care in order to be able to go to work, and, elder day care. *Claim-based reimbursement plan (no benefit card); participants must submit claim(s) to receive accrued funds.*

❻ Certification. *I hereby authorize a salary reduction agreement for the amount(s) shown above and understand that:*

- ebm will hold these funds until eligible expenses are incurred and submitted. **Funds may be forfeited** in accordance with Internal Revenue Service (IRS) Publication 969 if eligible expenses are not incurred or submitted for reimbursement by plan year deadline or purchased utilizing the FSA benefit card (if applicable) within the plan year or date upon which active employment ends, whichever comes first.
- FSA expenses must be consistent with allowable deductions under IRS Publication 969.
- **This election cannot be revoked or changed** during the plan year unless the participant experiences a qualifying event as defined by the IRS.
- **Participants must re-enroll each plan year during the employer's annual open enrollment period; re-enrollment is not automatic.**
- **Health Care FSA cards**, if offered by your employer's plan, are reloadable; keep until they expire; cards will reload at the start of each new plan year for which you have re-enrolled. Additional and replacement cards are available from Mastercard for a nominal fee
- Health Care FSA plan has a **Rollover option**. See note above. Rollovers take place after the current plan year's 90-day claim submission ("runout") period has closed.
- Claims for reimbursement of eligible expenses incurred during the Plan Year must be submitted **within 90 days** following the last day of the Plan Year.
- **Tax advice:** It is suggested you consult with a tax advisor to determine your tax savings and/or limits on tax deductions.
- **Additional certification for Dependent Care Plan Participants**: *I understand that the Dependent Care Reimbursement Plan Guidelines and qualifications can be found at www.irs.gov/pub/irs-pdf/p503.pdf and attest that I and my dependent(s) qualify to participate for the plan year noted above. I agree to notify the plan administrator should I experience a change in need or no longer meet the IRS's eligibility criteria and submit claims(s) for each plan year enrolled.*

➤ **Signature:** _____ **Date:** _____

Employer: Add deduction info. at top & upload to your secure employer portal at: *getebm.com/spending-accounts*.