CITY OF Salem AT YOUR SERVICE

Flexible Spending Account (FSA) Enrollment or Waiver form 2021

Employer **City of Salem (Group # 0000373)**		E-mail Address		
Employee Last Name	First Name	M.I.	Gender	Marital Status ☐ Single ☐ Married
Social Security Number **(Required)**	Date of Birth	Phone Number		
Current Mailing Address Street	City	State	Zip	

I authorize my employer to withhold a portion of my pre-tax employment compensation and deposit these funds into my elected flexible spending account (FSA) as listed below. **Elections are annual and are deducted from the first two paychecks of each month. 24 deductions for a full calendar year or the number of paychecks remaining in the calendar year.**

HEALTH CARE SPENDING ACCOUNT: $_____ Annual Election
*Cannot exceed **$2,750.00** for the calendar year*

DEPENDENT CARE (DAYCARE) SPENDING ACCOUNT: $_____ Annual Election
Elections cannot exceed the lower of either spouse's earned income, $5,000 annual maximum if head of household or married filing jointly or $2,500 if married filing separately. Most commonly used for Daycare expenses.

In Consideration of my employer allowing me to participate in the Flexible Spending Account (FSA), I acknowledge and agree as follows:

Accept Plan Terms: I agree to abide by the terms, conditions and provisions of the FSA contained in my employer's Plan Document. I acknowledge my right to examine the Plan Document or obtain a copy of it by giving reasonable advance notice to the plan administrator and paying a reasonable copy cost.

Responsibility: I acknowledge that the Internal Revenue Code permits me to claim reimbursement only for my tax deductible expenses incurred after the effective date of my FSA elections, and I assume full responsibility for all taxes, penalties, interest or other consequences which may be assessed to me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursements from my FSA for disallowed expenses.

Dependent Care: I understand that the Internal Revenue Code prohibits me from claiming the Federal Child Care Tax Credit for dependent care assistance expenses which are reimbursed to me from my FSA.

Plan Modification: I have been informed that the FSA plan offered by my employer may be modified from time to time, and I agree that my employer may cancel or amend the plan according to their independent judgment and discretion without my consent or prior notice to me.

Social Security: I choose to participate in the FSA plan despite my knowledge that my salary reduction elections may reduce my FICA withholdings (Social Security) and that this may reduce my Social Security benefits upon retirement.

Forfeiture: I understand that I must claim reimbursement for eligible expenses incurred during the plan year on or before 90 days after the last day of the plan year or I will forfeit those reimbursements. I further acknowledge that I will forfeit all funds credited to my FSA which are not reimbursed to me.
***** Please note: Reimbursements must be RECEIVED by the last day of the run-out, not postmarked.**

Seek Advice: I have been informed that my participation in the FSA will have tax and economic consequences to me and that before deciding to participate in the FSA I may wish to seek professional advice regarding the benefits, risks and limitations of the FSA.

ENROLLMENT AGREEMENT FOR CURRENT YEAR:

Employee Signature: _____ **Date:** _____
By my signature, I acknowledge enrollment in the current year FSA account

WAIVER OF PARTICIPATION FOR CURRENT YEAR:

Employee Signature: _____ **Date:** _____
By my signature, I acknowledge that the FSA has been offered to me and I elect not to participate

Employer Use Only

Employee hire date: _____
Employee effective date of coverage: _____
EBMS Division#: _____
FSA Tracking List: ☐
Email form to EBMS email: flex@ebms.com ☐
Oracle: B005 ☐ B004 ☐ Oracle Entry date: _____

HR Representative : _____ **Date:** _____

Employee #: _____
Employee first contribution date: _____
# of pay-periods remaining for the year: _____
Health Care B005: Per Paycheck $ _____ Per Month $ _____
Dependent Care B004: Per Paycheck $ _____ Per Month $ _____