Reimbursement Account Enrollment Form

Please print clearly and return completed form to your Employer

Employee Information

Employee Name _____
Last Name First Name MI

Employer CITY OF HAVERHILL Div/Loc/Dept# SCHOOLS

SSN / Employee ID _____

Please enter your SSN or Employee ID. Many employers use an ID other than SSN with Crosby Benefit Systems. If you are unsure which number to use, please contact us or your HR/Benefits department.

Home Address _____

_____
City State Zip

Date of Hire _____/_____/_____ Date of Birth (required) _____/_____/_____ Phone (_____)_____

Payroll Mode: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Other _____

Go Paperless!

Enter your email address below to receive communications by email rather than US Mail:

Email Address _____

You may cancel this request at any time by emailing Crosby at servicecenter@crosbybenefits.com.

☐ Store my email address but opt me out of receiving all electronic email communications.

Direct Deposit

I authorize Crosby Benefit Systems to deposit my full reimbursement into my:

___**CHECKING** account or ___**SAVINGS** account *(please choose one)*

Routing/Transit Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account Number: _____

Medical Care FSA

(HR Use Only)
Effective Date:
____/____/ 16

☐ **I elect to participate in the MEDICAL CARE Reimbursement Account** sponsored by my employer.

I elect to contribute $_____ Annually.

HR Use Onlv

Dependent Care FSA

(HR Use Only)
Effective Date:
____/____/ 16

☐ **I elect to participate in the DEPENDENT CARE Reimbursement Account** sponsored by my employer.

I elect to contribute $_____ Annually.

HR Use Onlv

Employee Certification

I understand that my annual Flexible Spending Account election may require adjustment to comply with IRS Section 125, 129 and 105 nondiscrimination guidelines. I also understand that I may not change or stop deposits to the account(s) indicated above until the end of the plan year unless I have a change in status, as defined by IRS regulations and my employer's plan. ***If I do not use all the money in my account(s) during my dates of participation, I understand that any balance will be forfeited***. I understand that there will be no interest build-up in the account(s). I have read and understand the rules and regulations on the reverse side of this form.

I certify that the Flex Debit Card, if applicable, will only be used for expenses considered eligible as defined under the Flexible Spending Account Summary Plan Description. I certify that these expenses have not been and will not be reimbursed through any other means, including my or my dependent's insurance plans. I will repay funds in the event that I misuse the Flex Debit Card to authorize payment of any non-eligible expenses, or fail to provide sufficient documentation within the stated time frame, as explained in the *Supporting Documentation* section on the reverse side of this form.

My signature authorizes reductions from my pay checks for the purpose of funding my tax-free reimbursement account(s).

X Employee Signature _____ Date _____

For HR Use Only:

Authorized by _____ **Date** _____

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Benefits People

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

MEDICAL

ELIGIBLE EXPENSES:

In general, an employee may be reimbursed for a health care expense which is deductible for federal income tax purposes, but which has not and/or will not be reimbursed by any other source, and which has not been nor will not be deducted on the employee's income tax return. Some examples of eligible expenses include co-insurance and deductible amounts; vision, hearing, dental, over-the-counter medical supplies; and prescription drug expenses not covered by your health insurance.

INELIGIBLE EXPENSES:

Examples of ineligible expenses include insurance premiums; vitamins/supplements for general good health; cosmetic procedures, products and prescriptions; and counseling not related to a medical condition.

SUPPORTING DOCUMENTATION:

The following forms of supporting documentation may be attached to the reimbursement request form:

Expenses covered by your health care plan:

Medical and dental expenses covered by your health care plan must be submitted to that plan. You may submit an Explanation of Benefits Statement with a reimbursement request for the portion of your claim not paid by your health care plan.

For all expenses, you must attach bills or evidence of payment that clearly state all of the following:

1. Name of person receiving the service
2. Nature of service or supplies (includes medication name)
3. Name of service provider
4. Amount reimbursable under the plan
5. Date(s) service was rendered

DEPENDENT**

ELIGIBLE EXPENSES:

The annual amount reimbursed cannot exceed the earned income of the lower-paid spouse or $5,000, whichever is less. If you are married, filing separately, your annual reimbursement cannot exceed $2,500.

The expenses must be employment-related and incurred for the care of a dependent of the employee who is under age 13 and for whom the taxpayer is entitled to a dependent deduction under Internal Revenue Code Section 151(c), or is a dependent of the employee who is physically or mentally incapable of caring for himself or herself, resides with the employee for more than half of the year, earns below $3,200 and will not be deducted or taken as tax credits on the employee's federal and/or state income tax return for any year.

The payments cannot be made to a person who is claimed as a dependent by the employee.

Expenses for DAY camp programs are allowable; however, if camp hours exceed the employee's working hours, submit ONLY that portion of expenses incurred for work-related hours. **OVERNIGHT CAMP is NOT an allowable expense**, even on a prorated basis.

SUPPORTING DOCUMENTATION:

For all expenses, you must submit bills or evidence of payment that clearly state all of the following:

1. Name of person receiving the service
2. Name of service provider
3. Nature of service
4. Amount reimbursable under the plan
5. Date service was rendered
6. Provider's Tax ID Number

****QUALIFICATION GUIDELINES FOR A DEPENDENT CARE ACCOUNT**

To qualify, both the employee and spouse must be working, or one working and the other enrolled as a full-time student, or actively looking for work. If the employee is single, divorced or legally separated, the employee's need for dependent care assistance must be work related.

PLEASE NOTE

Service dates for reimbursable expenses must fall within the plan year. Reimbursement requests not submitted during the plan year must be submitted prior to the end of the run out period. Please contact your Human Resources Department or Crosby Benefit Systems for more information.

Over-the-counter medicines and drugs can only be reimbursed if prescribed by a physician. This change does not apply to medical supplies such as insulin even if purchased without a prescription, or other health care expenses such as medical devices, eyeglasses, contact lenses, bandages, co-pays and deductibles.

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