City of Newton Flexible Benefits
ENROLLMENT FORM

PLEASE PRINT CLEARLY:

Once completed, please return this form to Human Resources.

Employee Information

Employee Name ____
Last Name First Name MI

Soc.Sec.No. ________-_______-_______ Date of Birth _____/_____/_____ ____________________________

Home Address ____

____
City State Zip

Home Telephone No. (_______)_______________ Work Telephone No. (_______)_______________
area code area code

I am a Municipal Employee: ☐ I am a School Department Employee: ☐

I Get Paid: Weekly ☐ Semi-monthly ☐ 24 Pay Checks ☐ 20 Pay Checks Monthly ☐

Medical Care Reimbursement Account

☐ I elect to participate in the Medical Care Reimbursement Account program sponsored by the City of Newton.

Further, I elect to contribute **$**________________ Annually. Maximum allowed is $2,500.

Dependent Care Reimbursement Account

☐ I elect to participate in the Dependent Care Reimbursement Account program sponsored by the City of Newton.

Further, I elect to contribute **$**________________ Annually. Maximum allowed is $5,000.

Beneficiary Designation

In the event of my death, the person named below is my designated beneficiary:

Name ____________________________________ Relationship ____________________________

Spouse and Dependent Information *(Optional)*

If expenses for reimbursement are for your spouse or dependent children, please complete the following.

Name	Relationship to Employee	Date of Birth

Employee Certification

I understand that my annual FSA 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) by the end of the Plan Year, 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.

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

X Employee Signature ____________________________________ Date ____________________

For Human Resources Only **Plan Year:** _______________ **Effective Date:** _______________

Annual Salary: ____________________________________

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 or 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 medications; 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 attach the Explanation of Benefits Statement to the reimbursement request form 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 and address of provider of services
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.

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:

The following supporting documentation should be attached to the reimbursement request form:

1. Name of person receiving the service
2. Name and address 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 the Human Resources Department at (617) 796-1260 or Cafeteria Plan Advisors (CPA, Inc.) for more information.

CPA, INC.
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Braintree, MA 02184
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(781) 848-8477 (Fax
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