City of Stamford
Flexible Reimbursement Account

PLEASE NOTE: If you are enrolled in the High Deductible Health Plan (HDHP), you are not eligible to enroll in the Health Care Flexible Reimbursement Account.

2018 ENROLLMENT FORM

Social Security Number: ______________________________ Employee ID#:______________

Name: ____ Contact#____________________

Last First Middle

Address: ____

Street City State Zip

Date of Birth_________________________ Date of Hire_________________________

Effective Date________________________

In accordance with my rights under the Plan, I elect the following benefits for the 2018 Plan Year. I agree that my paycheck will be reduced by the amounts necessary to pay for my elected options.

Election for MEDICAL CARE Reimbursement

(Must re-enroll yearly)

( ) I elect to receive **MEDICAL REIMBURSEMENTS** for the Plan Year 2018. The amount of salary redirection will be $_________________ for the Plan Year. **(The total amount cannot exceed $2,650.)**

OFFICE USE ONLY
WEEKLY AMOUNT
$_______________

I understand that:

Reimbursement will be available only for "qualified medical care expenses." Generally, "qualifying medical care expenses" are those medical expenses normally deductible on my Federal Income tax return (without regard to the percentage of adjusted gross income limitation). I agree to notify the City of Stamford, if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.

If I cease my employment with City of Stamford, my participation in the Plan will cease, subject to any COBRA regulations. No further contributions will be made to the Plan on my behalf and I may be entitled to reimbursements for claims incurred prior to my date of termination.

I understand that I cannot seek reimbursement from this account for a medical expense which I intend on taking as a deduction on my tax return.

(Note: This is a two page form. Both pages must be submitted)

Election for DEPENDENT CARE Reimbursement

(Must re-enroll yearly)

(   ) I elect to receive **DEPENDENT CARE** reimbursements for the Plan Year 2018. The amount of salary redirection will be $___________for the Plan Year. **(The total amount cannot exceed $5,000)**

OFFICE USE ONLY
WEEKLY AMOUNT
$_______________

I understand that:
Reimbursement will be available only for "qualifying dependent care expenses" as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description. I agree to notify the City of Stamford, if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense.

I agree to provide the Administrator with a statement from the service provider that includes the amount of the expense as proof that the expense has been incurred.

I agree to provide the Administrator with the name, address, and if applicable, the taxpayer identification number of the service provider.

I will only be reimbursed for amounts up to the balance in my account at the time of my request.

I cannot claim a dependent care tax credit on amounts I receive as reimbursements under this dependent care reimbursement program.

Other Terms and Conditions

I understand that:
I cannot change or revoke any of my elections on this Enrollment Form at any time during the Plan Year unless I have a change in family status (including marriage, divorce, legal separation, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I taking an unpaid leave of absence, a substantial change in my family's health coverage due to a change in my spouse's employer-sponsored health coverage, or such other events as the Plan Administrator determines pursuant to law will permit a change or revocation of an election).

Any amounts that are not used during a Plan Year to provide benefits will be forfeited and may not be paid to me in cash or used to provide benefits specifically for me in a later Plan Year.

Prior to the first day of each Plan Year I will be offered the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return a new election form at any time, I will be treated as having elected not to participate in the Plan for the upcoming Plan Year.

I have received and read the Enrollment Materials and Plan Description which constitutes my Summary Plan Description.

____________________________	________________________	_____________
Employee Signature	Print Name	Date

(Note: This is a two page form. Both pages must be submitted)