



2016 Health/Dependent Care Flexible Spending Account Enrollment Form

Social Security Number

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First Name	MI	Last Name
Address		
City	State	Zip Code
Department		Telephone Number

I hereby elect to participate in the City of Hickory Medical and/or Dependent Day Care Reimbursement Plans for the calendar year beginning January 1, 2016 and ending December 31, 2016. I have reviewed the terms of the Plan and I understand I may elect coverage under either or both of the accounts below, subject to the terms of the Plan, for the Plan Year beginning January 1, 2016.

Health Care Flexible Spending Account

Contribution Per Pay Period Maximum **52 weekly or 24 semi-monthly** X Number of Pay Periods in plan year = Your Annual Election Amount (\$2550)

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Dependent Care Flexible Spending Account

Contribution Per Pay Period **52 weekly or 24 semi-monthly** X Number of Pay Periods in plan year = Your Annual Election Amount (Cannot exceed \$5000) per Household

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I understand that;

Only qualified medical and/or dependent care expenses (incurred after my effective date and within the calendar year) may be submitted for reimbursement.

My annual compensation will be reduced by the amounts elected above.

I cannot change or revoke my election unless I have a legal family status change. My election must be due to and consistent with marriage, divorce, death of a spouse or child; termination or commencement of spouse's employment; taking an unpaid leave of absence by me or my spouse ; or switching from full time to part-time employment, switching from part-time to full time employment status by me or by my spouse. The only exception involves my Medical Reimbursement Account election, which cannot be decreased for any reason during the calendar year, unless I experience a death of my spouse or child. The request to change an election must be made within 30 days from the date of the family status change.

This agreement is subject to the terms of the City of Hickory Medical and Dependent Day Care Reimbursement Plans.

Signature _____

Date _____

*Annual Maximum
 Medical Reimbursement \$2550 per calendar Year
 Dependent Day Care Reimbursement \$5000 per calendar year (married filing joint tax return)
 \$2500 per calendar year (married filing separate tax return)

Reminders:

- In 2016, over-the counter (OTC) medications will no longer be eligible for reimbursement without prescription.
- You MUST re-enroll each year to contribute to the FSA account.
- FSA's have the "Use It or Lose It" policy, which means any amounts unused during the calendar year are forfeited.

Health Care Reform Law- Effective January 1, 2011 "the IRS says a prescription is required for over-the-counter medications such as nonprescription pain relievers, cold medicines, antacids, and allergy medications in order to be reimbursed. It defines a prescription as a "written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which a medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state."