Risk Management Department / Group Benefits Division

2023 FSA HC/FSA DC Enrollment Form for Calendar Year 2024

ENROLLMENT TYPE: ☐ New Hire ☐ Qualifying Status Change ☐ Open Enrollment

NAME: _____ **Last 4 digits of Soc. Sec. No. or EE No.** _____

ADDRESS: _____**CITY/STATE:** _____ **ZIP:** _____

WORK (_____) _____ - _____ HOME: (_____) _____-_____ CELL: (_____) _____-_____

PART I – ENROLLMENT

☑ **I choose to enroll in the FSA Healthcare Account with an annual contribution of $**_____

(***Maximum $3,200 per year*** *– Up to a maximum of unused $640 can be carried over into the new plan year.* ***(Carryover does not apply to Dependent Care FSA)***

☐ **I choose to enroll in the FSA Dependent Care Account with an annual contribution of $**_____

(*Maximum $5,000 but $2,500 maximum if you and your spouse enroll in separate Dependent Care FSA*)

PART II – CHANGE DUE TO A QUALIFYING EVENT DATED _____/_____/_____

My qualifying event is: (check one)

☐ Marriage ☐ Domestic Partnership (DP) ☐ Divorce ☐ Termination of Domestic Partnership ☐ Birth or Adoption of a child

☐ Start or loss of your spouse/DP's employment ☐ Change in Employment Status (from FT to PT or vice versa) ☐ Death of your spouse/DP ☐ **OTHER** (covid-19)

FSA Healthcare (FSA HC – cannot stop participation due to rollover clause):

☐ Increase annual amount ☐ Decrease annual amount New annual amount: $_____

FSA Dependent Care (FSA DC):

☐ Increase annual amount ☐ Decrease annual amount ☐ Stop participation New annual amount: $_____

EMPLOYEE AUTHORIZATION

I understand the choices I have indicated above are **IRREVOCABLE** unless a "qualifying event change" occurs as defined by the Internal Revenue Service. I understand that I will forfeit any balance remaining in my account at the end of the Plan Year, in accordance with the Internal Revenue Service Section 125, if eligible expenses are not incurred during my eligible period of participation equal to the account balance and if claims for expenses are not filed within the required time period. I understand if I am terminated, discharged or have my hours reduced to less than thirty (30) hours per week, I will be automatically terminated from the plan. If termination from the plan occurs either voluntarily or involuntarily, or if I stop all contributions:

- No benefits will be paid for any expenses incurred for dependent care services after the termination date; and
- Any plan contributions made after the termination date will be refunded and subject to taxation.

I hereby authorize CIGNA HealthCare to submit my unpaid, eligible CIGNA HealthCare medical and/or CIGNA Dental expenses to the FSA for payment consideration. I certify that any expenses submitted to the FSA or paid for with the FSA Debit Card on my behalf have been incurred by me or my eligible dependents and have not been reimbursed by any other source, nor do I expect them to be. I agree to notify the CIGNA HealthCare Reimbursement Account Unit immediately if any of these expenses are reimbursed from any other source.

I hereby authorize the City of Miami to make adjustments to my salary in accordance with the above elections. I have read and fully understand the rules and provisions governing the plan. If for any reason the information provided above should change, I will immediately notify my employer within 30 days of event. I understand that falsification of any information on this application or pertaining to my reimbursement may result in termination of my employment and will require full reimbursement by me of all benefits paid under this plan. Additionally, I further understand that falsification of any information may subject me to prosecution by the Internal Revenue Service.

Signature: _____ **Date:** _____

Completed forms must be submitted to Group Benefits Division located in MRC's 9th Floor