

CITY OF BAKERSFIELD

SECTION 125

Flexible Spending Accounts (FSA) Plan Enrollment Form

Fax 852-2070 or submit your completed and signed form to Human Resources

PRINT IN BLACK OR DARK INK:

Last Name	First Name	Middle Initial				
CA						
Home Address: Street	City	State Zip Code				
<table style="width: 100%;"> <tr> <td style="width: 60%;">Email Address: _____</td> <td>Work phone #: _____</td> </tr> <tr> <td>Social Security Number: _____</td> <td>Home/Cell #: _____</td> </tr> </table>			Email Address: _____	Work phone #: _____	Social Security Number: _____	Home/Cell #: _____
Email Address: _____	Work phone #: _____					
Social Security Number: _____	Home/Cell #: _____					

Please enter the annual amount on the Annual Election line only.

The Benefits office will enter the Per Pay Period amount.

The following deductions are bi-weekly (26 pay periods/year)

I authorize the following to be deducted Pre-tax:	Annual Election:	Per Pay Period: (office only)
<input type="checkbox"/> Unreimbursed Medical Eligible Expenses (\$2,000 per employee)	\$ _____	\$ _____
<input type="checkbox"/> Dependent Care Expenses (\$5,000 per family)	\$ _____	\$ _____
Unreimbursed Medical and/or Dependent Care Accounts(s)	SUB TOTAL \$	\$ _____
The following administrative fees will be charged pre-tax per pay period:	\$	2.31
	TOTAL \$	\$ _____

AUTHORIZATION:

The undersigned participant in the Flexible Benefits Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) while the undersigned was covered under the Employer's Flexible Benefits Plan and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or dependent care tax credit is permitted for amounts for which reimbursement is made.

Signature

Date