CITY OF NEWPORT NEWS
FLEXIBLE BENEFIT PLAN
SALARY ADJUSTMENT AFFIDAVIT
JANUARY 1, 2019 – DECEMBER 31, 2019

DEDUCTION EFFECTIVE

I, _____, Employee ID# _____
(Please Print)

_____
*****Mailing Address (including city, state, and zip code)

_____
Work Phone # Home Phone #

an employee of the employer noted above, do hereby elect to participate in my employer's Flexible Benefit Plan and to be reimbursed for the expenditures indicated below, all of which I will incur during the above Plan Year. Each of the declared amounts indicated below are reimbursements and satisfy the requirements under the Flexible Benefit Plan as described in the employer Plan Document.

I hereby authorize my employer to reduce my gross compensation each **BI-WEEKLY** pay period by an amount equal to the total of these expenditures. **(26)**

	Per Pay Period	Annual Election
HEALTH CARE REIMBURSEMENT ACCOUNT (Qualified un-reimbursed health care expenses) **Max. Annual Election: $2,650.00**	$_____	$_____
DEPENDENT CARE REIMBURSEMENT ACCOUNT (Qualified child care and dependent care expenses) **Max. Annual Election: $5,000.00**	$_____	$_____
TOTAL	$_____	$_____

Treatment of Unused Declarations

If, at the end of the Plan Year, the total of my declared reduction in compensation exceeds my substantiated incurred expenses, I recognize that the difference in the amounts will be forfeited. I further acknowledge that the above listed amounts shall be irrevocable until the beginning of the next Plan Year unless there is a material change in my family situation of a nature permitting a mid-year change under IRS regulations.

BENEFITS CARD ELECTION

- ☐ I am a **New Participant** and I elect to be issued a Benefits Card.
- ☐ I am a **Renewing Participant** and my card has been **lost/destroyed**. Please re-issue me a new Benefits Card.
- ☐ I would like to have a second card issued to my dependent (age 18 and over), whose name and social security number are indicated below.
- ☐ My dependent's card has been **lost/destroyed**. Please issue a new card to the dependent below.

_____
Dependent Name ***Dependent Social Security Number***

Benefits Card Certification

I acknowledge that I will agree to the terms and conditions of the Cardholder Agreement received with my BENEFITS CARD and certify that I will only use the card for qualified health care and/or dependent care expenses. I further certify that I will not seek reimbursement under any other health plan coverage for claims that have been paid for by the card, nor will I use the card for expenses that have been paid by any other health plan benefit. I acknowledge that I will, upon request of the Plan administrator, provide required documentation of expenses.

*****THIS IS A 2-PAGE FORM*****

AUTHORIZATION FOR CLAIMS COMMUNICATION TO BE SENT VIA EMAIL

I authorize Flexible Benefit Administrators, Inc. to send me information regarding my claims via email. I understand that I will no longer receive claims communication via U.S. mail to my home address.

It is also my responsibility to notify Flexible Benefit Administrators, Inc. if this information should change or if I elect to stop correspondence via email.

_____ _____

EMPLOYEE NAME EMAIL ADDRESS

_____ _____

HOME TELEPHONE NUMBER SIGNATURE

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (CREDITS)

☐ My Flexible Spending Account Direct Deposit information will remain the **SAME AS LAST YEAR.**
(Skip bank information and sign and date at the bottom of this box)

I hereby authorize **CITY OF NEWPORT NEWS**, hereinafter called **EMPLOYER**, to initiate credit entries to my

_____ ☐ **checking** ☐ **savings**

(name of bank)

account indicated below and the depository named below, hereinafter called **DEPOSITORY**, to credit the same to such account. I also authorize the **EMPLOYER** to draw drafts on my account or to initiate debit entries to my account, for the purpose of withdrawing money from my account, but solely in order to adjust an error resulting from a deposit or credit entry that has been made under this Authorization in an amount that is not correct. The **DEPOSITORY** shall not be liable for honoring any draft, debit entry or withdrawal initiated by the **EMPLOYER**.

Depository Name	Office
Bank Transit/ABA Number:	Account Number:

This authority is to remain in full force and effect until termination from the Plan or notification in writing by the participant.

_____ _____

EMPLOYEE NAME SOCIAL SECURITY NUMBER

_____ _____

DATE SIGNATURE

NOTE: FOR NEW ACCOUNTS, PLEASE ATTACH A VOIDED CHECK TO THIS AUTHORIZATION AGREEMENT.

I hereby certify that I have examined this Salary Adjustment Affidavit and to the best of my knowledge and belief, it is true, correct, and complete.

_____ _____

DATE SIGNATURE

_____

WITNESS

*** Please notify Flexible Benefit Administrators, Inc. if you have a change of address.**