



Plan Year 2027 Enrollment/Change Form Flexible Spending Accounts (FSA) Program

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Please review the FSA Program Brochure on the FSA website, and Pages 5 and 6 of this form before completing.

Program (Check One):	☐ HCFA	☐ DeCAP	☐ HCFA and DeCAP
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Enrollment Period (Please select one option):

☐ Open Enrollment Period (October 1, 2026 - November 13, 2026) – Do not complete Section C
☐ Qualifying event enrollment/change: (January 1, 2027 - November 12, 2027) - Please complete all appropriate sections, including Section C for mid-year enrollment.
☐ Newly Eligible Employee: Hire Date: _____ Benefit effective date, if later than hire date: _____
☐ Change: ☐ Name ☐ Address ☐ Agency Transfer ☐ Add Dependent
☐ HCFA Only - Continuation of Coverage to accelerate payroll deductions*: Last pay date: _____ Last date at work: _____ * Please refer to page 3 for detailed information

Section A – Employee, Spouse and Dependent information

Employee (Participant) Information (All section must be completed)

Social Security Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Home Address (Street and Number) _____

Apt. _____ City _____ State _____ Zip Code _____

Mobile Phone Number: _____ Email: _____

Federal Marital Status	☐ Single ☐ Divorced ☐ Legally Separated ☐ Married ☐ Separated ☐ Widowed
Agency Name (Not Division): (CUNY- Please specify name of college)	
Weekly payroll	☐ Yes ☐ No

Spouse Information (Please note: domestic partner/civil unions are not eligible for the FSA program)

Social Security Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Employment Status * Must provide proper documentation under DeCAP	☐ Full-Time Student* ☐ Disabled* ☐ Employed ☐ Unemployed (Not eligible under DeCAP) ☐ Self-Employed (Need description of occupation on letterhead)
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Dependent Information (List all your eligible dependents. Check this box ☐ if attaching an additional page)

Full Name	Social Security Number	Date of Birth	Age	Relationship to employee*
				☐ C ☐ AC ☐ DC
				☐ C ☐ AC ☐ DC
				☐ C ☐ AC ☐ DC
				☐ C ☐ AC ☐ DC

For DeCAP: The Dependent must be claimed on your income tax return and under the age of 13.

*Relationship to the employee:

C- Child Under age 13

AC- Child age 13 - 26

DC- Disabled Child (Must provide proper documentation)

Section B – Annual contribution amount*(January 1 2027 – December 31, 2027)

Program	Amount
Health Care Flexible Spending Account Minimum \$260-Maximum \$3400 By notification of IRS, maximum contribution allowance could increase.	\$ _____
Dependent Care Assistance Program Minimum \$500-Maximum \$7500	\$ _____
Does your spouse participate in their employer DeCAP that you take part in? The total combined Plan Year dollar amount for you and your spouse cannot exceed \$7,500	☐ No ☐ Yes Amount \$ _____

Section C – Qualifying Event Enrollment/Change

Indicate the Qualifying Event incurred and attach appropriate documentation. You must return this form within 30 days after the Qualifying Event indicated and be submitted with appropriate documentation to be processed. This change must be consistent with your Qualifying Event and described on Page 4 of this Enrollment/Change Form.

Please select your Qualifying Event:

HCFSA and DeCAP Qualifying Events and Required Documentation	DeCAP Only Qualifying Events and Required Documentation
☐ Marriage [Marriage certificate] ☐ Birth of a child [Birth certificate] ☐ Death of participant ☐ Adoption of a child [Adoption agreement and employee's tax return showing eligible dependents] ☐ New employee [Letter from employer/agency] ☐ Termination of employment (self) [Letter from employer/agency] ☐ Approved unpaid leave of absence [Letter from employer/agency]	☐ Divorce/legal separation/annulment [Divorce, annulment decree/separation agreement] ☐ Death (spouse or dependent) [Death certificate] ☐ Change from FT to PT employment or vice versa-Letter from employer/agency (self, spouse)] ☐ Termination of employment [Letter from employer (self, spouse)] ☐ Reduction or increase of hours worked [Letter from employer (self, spouse)] ☐ Ineligibility of dependent [Birth certificate or other appropriate documentation]

Qualifying Event Date: _____

Section D – Direct Deposit Information (Must attach Voided Check)

Claims are reimbursed through Direct Deposit. Please select one option:

☐ **New enrollment.**

*Voided check attached to this form

☐ **Participated in FSA in Plan Year 2026.**

Direct Deposit Information on file.

Note: New enrollments request will not be processed without supporting documentation.

Section E – Authorizations, Annual Salary Reduction Agreement and Certification of Qualifying Event

Please read carefully before signing.

1. **Authorization and Annual Salary Reduction Agreement.** I have read the printed material explaining the HCFSAs and/or DeCAP benefits and my choices under these programs. I have also read the Enrollment/Change Form information on Pages 5 and 6 of this form.
2. **I understand that by signing and submitting this Enrollment/Change Form:**
 - I am making a binding election as to my benefit coverage for the Plan Year that begins on January 1, 2027
 - I authorize my Employer to reduce my gross salary as indicated on this form to pay for the benefits I have elected.
 - My payments will be pro-rated over each payroll.
 - **My HCFSAs election cannot be reduced or revoked for any reason except for termination of employment during the Plan Year, or if I should take an unpaid leave of absence.**
 - I agree to pay, in full, the amount elected on this form for the Plan Year for HCFSAs, by recalculating the payroll deductions upon returning from unpaid leave.
 - My HCFSAs and/or DeCAP election can only be changed if I experience a Qualifying Event (Section C).
 - Each account is separate and that DeCAP funds cannot be used for or transferred to HCFSAs or vice-versa.
 - Any amount remaining in these FSAs that is not used during the Plan Year and HCFSAs Grace Period, if applicable, will be permanently forfeited by me.
 - I am only eligible to receive reimbursement on behalf of my eligible dependents listed on this form.
 - will be terminated from participation in the Program if I cease employment with the City of New York or go on an unpaid leave of absence, unless I elect to participate in the Continuation Coverage for HCFSAs.
 - **The FSA program does not utilize debit cards**
3. **Direct Deposit Authorization:** I hereby authorize the Flexible Spending Accounts Program to deposit my HCFSAs/DeCAP reimbursement directly into my checking or savings account as requested. I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the “National Automated Clearing House Association” operating guidelines and rules, the Flexible Spending Accounts Program can only reverse the amount of the incorrect direct deposit. I agree that this authorization will remain in effect until I provide to the Flexible Spending Accounts Program with a written cancellation to terminate the service. I will notify the Flexible Spending Accounts Program if my bank account information should change.
4. **Qualifying Event:** This is to certify that I incurred the Qualifying Event indicated in Section C and, therefore, wish to modify my benefits as indicated. I understand that the change(s) in benefits requested must be consistent with the Qualifying Event, and that I must provide approved documentation of all change(s), and that the effective date of the change(s) will be the date the forms are received by the Plan Administrator or the date of my first payroll deduction if I become eligible after the beginning of the Plan Year. The participant has the burden of proof to show that the Qualifying Event is acceptable under the Plan. The Plan Administrator reserves the right to request additional information. The Plan Administrator has, among other duties, the power and duty to interpret the Qualifying Event and to resolve ambiguities, inconsistencies and omissions

Section F – Employee/Participant Signature

Signature: _____

Date: _____

You may submit your completed form(s) in the following ways:

- Forms/documents can be sent via secure email to: <https://nyc-fsa.leapfile.net>
- Forms can be mailed to:
The Flexible Spending Accounts Program
P.O. Box 707
Bowling Green Station
New York, NY 10274
- Express mail forms should be sent to:
NYC Flexible Spending Accounts Program
22 Cortlandt Street, 28th Floor
New York, NY 10007

Please see more information below.

Plan Year 2027 Enrollment/Change Form Flexible Spending Accounts (FSA) Program

The Health Care Flexible Spending Account (HCFSA) Program and the Dependent Care Assistance Program (DeCAP) are divisions of the Office of Labor Relations' Flexible Spending Accounts Program
nyc.gov/fsa

By signing the Enrollment/Change Form:

- I authorize my Employer to reduce my gross salary before federal income taxes and Social Security (FICA) taxes are calculated by the total amount of the annual salary reduction (Plan Year 2026 contribution amount) indicated on Page 1.
- I understand that contributions to the FSA Program may reduce my Social Security benefits, since Social Security contributions will be based on my adjusted gross salary.
- I authorize the FSA Program to deposit my HCFSA/DeCAP reimbursement directly into my checking or savings account as requested (See Section D).

Under HCFSA

- I understand that the amount of salary reduction will continue throughout the Plan Year and cannot be reduced or revoked for any reason except for termination of my employment during the Plan Year or if I should take unpaid leave of absence.
- I understand that I may enroll in the Program or increase my contribution should I become eligible to participate in this Program or acquire new dependents during mid-year. I understand that I must complete all applicable sections of this form and submit it to the FSA Program Administrator within thirty (30) days after a Qualifying Event to enroll and/or add dependents. A Qualifying Event can be marriage, adoption or birth of a child, commencement of new employment with the City, or employee's return from approved unpaid leave of absence (taken during the Open Enrollment Period) or termination of participant's employment with the City of New York.
- I understand that I will be reimbursed for eligible expenses up to my total annual contribution amount, less the administrative fee and any claims previously reimbursed, regardless of the current balance in my account.
- I understand that any health care expense defined by the IRS as a non-deductible expense for income tax purposes shall be ineligible for reimbursement. I further understand that although an expense may be deductible for income tax purposes, it may be ineligible for reimbursement under this Program.
- I understand that my personal and claim information will not be released to any other individual unless I complete the Health Insurance Portability and Accountability Act (HIPAA) Protected Health Information (PHI) Authorization Form.
- I understand that I have the right to revoke my HCFSA HIPAA authorization at any time in writing by emailing the Program through the FSA website at nyc.gov/fsa.

HCFSA Continuation of Coverage - Employees Terminating Employment/Unpaid Leave of Absence

- If you terminate your employment with the City of New York or go on unpaid leave of absence during the Plan Year, you cannot submit any claims for services rendered after your termination date, or effective date of your unpaid leave of absence, unless you elect Continuation of Coverage. You may elect to deduct the remaining balance of your goal amount on a pre-tax basis either by lump-sum or pro-rated payroll deductions with the remaining paychecks, as long as the FSA Program Administrator can meet the payroll deadlines for the applicable pay dates. Otherwise, you may continue coverage by submitting payment to the FSA program with post-tax dollars.
- I understand that I will be terminated from participation in the HCFSA Program, unless I elect HCFSA Program Continuation Coverage. In this case, I agree to fund the balance of my HCFSA goal amount for the current Plan Year with either (a) pre-tax dollars deducted from my last paycheck(s) or accelerated for the remaining paychecks prior to leaving City service; or (b) post-tax dollars for the remainder of the current Plan Year.

- I understand that if I elect HCFSAs Program Continuation Coverage and would prefer that the balance of my goal amount for the current Plan Year be deducted from my last paycheck(s) or accelerated for the remaining paychecks on a pre-tax basis, I will notify the FSA Program Administrative Office in writing by emailing the Program through the FSA website at nyc.gov/fsa thirty (30) days prior to the date I cease employment, or as soon as possible for the FSA Program Administrator to meet payroll deadlines.
- I understand that if I take unpaid leave of absence, I must notify the FSA Program Administrative Office to recalculate the deduction amount upon my return from the unpaid leave of absence and the FSA Program Administrative Office may also recalculate the deduction amount if necessary, as long as it is within the same calendar year and within the payroll cut-off dates.
- I authorize the FSA Program Administrative Office to recalculate any missed HCFSAs payroll deduction amounts, if the FSA Program Administrator identifies such missed deductions.

Under DeCAP

- I understand that the amount of salary reduction will continue throughout the Plan Year, unless I incur an approved Qualifying Event.
- I understand that I must complete all applicable sections of this form and submit it to the Plan Administrator within thirty (30) days after a Qualifying Event in order for any change to be effective.
- I understand that I may enroll in the Program or increase my contribution should I become eligible to participate in this Program or acquire new dependents during mid-year. I understand that I must complete all applicable sections of this form and submit it to the Plan Administrator within thirty (30) days after a Qualifying Event to enroll and/or add dependents. A Qualifying Event can be marriage, adoption or birth of a child, commencement of new employment with the City, employee's return from approved unpaid leave of absence (taken during the Open Enrollment Period) or termination of participant's employment with the City of New York.
- I understand that I will be reimbursed up to the total current balance in my account less the administrative fee. Any amounts requested for reimbursement which exceed the current balance in my account will be carried forward to the next month.
- I understand that if I am married and my spouse is not employed, he/she must be either: a) incapable of self-care or b) a full-time student.
- I understand that I may not receive a benefit for eligible employment-related dependent care expenses incurred by me which is in excess of my Earned Income or the Earned Income of my spouse, if I am married.

Under HCFSAs and DeCAP

- I understand that if I do not experience accurate payroll deductions, it is my responsibility to notify the FSA Program immediately.
- I understand that the funds in these FSAs can only be paid out to reimburse eligible medical and/or dependent care expenses actually incurred after the start of my participation in the FSA Program and during the Plan Year and HCFSAs Grace Period, if applicable.
- I understand that I have the burden of proof to show that each medical and/or dependent care expense is reimbursable under the FSA Program, as well as eligible and reimbursable under all regulations (including the Internal Revenue Code).
- I understand that, under all circumstances, the FSA Program Administrator reserves the right to request additional information.
- I understand that the FSA Program Administrator has, among other powers and duties, the power and duty to interpret the FSA Program and to resolve ambiguities, inconsistencies, and omissions.
- I understand that if I participate in both the HCFSAs Program and DeCAP, I cannot transfer funds from one account to the other.
- I understand that there is a maximum administrative fee of \$4.00 per month per account.
- I understand that any amount remaining in these FSAs that is not used during the Plan Year, Claims Run-Out Period and HCFSAs Grace Period, if applicable, will be permanently forfeited by me.