Employee Consent Form

VIRGA

BARCODE

Social Security Number: ___ — ___ — ____

First Name | M.I. | Last Name

Prior First Name | M.I. | Prior Last Name

If you changed your name because of marriage, divorce, etc., enter the name used when you were a medical resident.

Number and Street or P.O. Box Number

City, town or post office | State | Zip Code

Note: If foreign address, enter the information in the following order: city, province or state, and country. Follow the country's practice for entering the postal code. Please do not abbreviate the country name.

E-mail Address

___ — ___ — ____

Daytime Phone Number

◯ **I consent** to Virginia Mason Medical Center collecting the Social Security and Medicare tax (FICA) refund on my behalf for **all applicable years** during which I was a resident.

◯ **I consent** to Virginia Mason Medical Center collecting the Social Security and Medicare tax (FICA) refund on my behalf for **only noted years** indicated below during which I was a resident. [Check all appropriate box(es), as applicable.]

◯ **I do not consent.**

◯ 1996 ◯ 1997 ◯ 1998 ◯ 1999 ◯ 2000 ◯ 2001

◯ 2003 ◯ 2004 ◯ 1st Quarter of 2005

For each year of consent, I represent that:

- I have not claimed and will not claim a refund or credit from the IRS for any overcollected FICA taxes from wages paid for services performed as a medical resident, or if I have, the claim was rejected.
- I did not receive a FICA tax refund or credit because of earning in excess of the social security wage base on my Federal income tax return (e.g., Form 1040).
- I understand that my Social Security earnings record will be corrected to reflect zero wages earned as resident for tax periods for which I received a refund. I understand that removing these wages could affect my eligibility to or the amount of future Social Security benefits.
- I give my consent to Virginia Mason Medical Center to file a Medical Resident FICA Refund Claim on my behalf for refunds of FICA taxes that Virginia Mason Medical Center withheld from my wages for services I performed as a medical resident.

SIGN HERE _____ Date:_____

Return your signed consent form (postmarked no later than **October 5, 2010**) to:

Virginia Mason Medical Center Claims Administrator
c/o Gilardi & Co. LLC
P.O. Box 1110
Corte Madera, CA 94976-1110

Keep a signed copy of the consent form for your records.