AC 3206 (Rev. 11/12)

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER
BUREAU OF STATE PAYROLL SERVICES

PRIOR YEAR SOCIAL SECURITY AND MEDICARE TAX REFUND CERTIFICATION

Section A: *The Agency is required to complete the following section.*

Agency Code:_____ Tax Year: _____

Employee Name:_____
FIRST MIDDLE LAST

NYS EMPLID: _____

Amount of Tax Refund: To be calculated by OSC

Reason for Refund: ☐ Workers' Comp ☐ Nonresident Alien ☒ Other – Explain:
Retroactive increase to the Pre-Tax Transit Benefit

Section B: *The employee is required to complete the following section.*

I, _____ , have not and will not file a claim with the Internal Revenue
(Print Name)
Service for a refund of the Social Security and Medicare taxes withheld and reported for the tax year and reason(s) identified above by my employer.

I give my consent to my employer to file a refund claim on my behalf for refunds of Social Security and Medicare taxes withheld from my wages that are now considered exempt for reasons identified above.

Employee Signature:_____ **Date:**_____

Address:_____ **Phone:**_____

Notice to Employee: *Due to the complexity of income tax laws, the employee may wish to seek advice or help from the Internal Revenue Service or a tax professional, regarding the tax implication of receiving this refund of Social Security and Medicare taxes***.**

PLEASE NOTE:
This form must be retained in the Agency payroll office for four (4) years and be made available upon request by the Office of the State Comptroller.