

Cafeteria Plan Advisors, Inc.  
420 Washington St. Suite 100  
Braintree, MA 02184  
Phone 781.848.9848  
[www.CPA125.com](http://www.CPA125.com)  
Email: [info@cpa125.com](mailto:info@cpa125.com)  
Fax 781.848.8477

## NEW HIRE/ CHANGE IN STATUS FLEXIBLE SPENDING PRE-TAX PAYROLL REDUCTION

**Form must be returned to CPA  
within 30 days of change**

**New Hire** or  **Change**

*HR Use Only*

First Payroll Deduction Date \_\_\_\_\_

Per Pay Period Amount \$ \_\_\_\_\_

### Personal Information

**Name:** \_\_\_\_\_ **Employer:** TOWN OF WEBSTER

**Mailing Address:** \_\_\_\_\_ **Plan Year:** date of hire/eligibility – 6/30/2020

**City, ST, Zip:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### Payroll Information:

I am a: Town Employee  School Employee

I am paid: Weekly 52  Bi-Weekly 26

**The following qualified change in election for the Cafeteria Plan is the result of one of the following:**

New Hire Date of Hire: \_\_\_\_\_  Qualifying Event Date: \_\_\_\_\_ Event: \_\_\_\_\_

### New Benefit Elections:

FSA Health Care Account (\$2,700 maximum) **Election for Remainder of Plan Year: \$ \_\_\_\_\_**

*FSA Debit Card included for the Health Care Account. \$500 Roll Over option in effect for this plan year for available balance in the Health Care Account*

FSA Dependent Care Account (\$5,000 maximum) **Election for Remainder of Plan Year: \$ \_\_\_\_\_**

*Confirm eligibility requirements prior to enrolling*

### Direct Deposit Information (Required if not on file with Cafeteria Plan Advisors, Inc.)

I hereby authorize Cafeteria Plan Advisors, Inc. to deposit my claim reimbursements directly to my bank. I also authorize drafts to adjust any over deposits that were credited to my account in error. I will contact Cafeteria Plan Advisors, Inc. immediately with any bank information changes.

**Name of Bank:** \_\_\_\_\_  **Checking**  **Savings**

**Routing Number (9 digits):** \_\_\_\_\_ **Account Number:** \_\_\_\_\_

### Certification

I hereby authorize a salary reduction agreement for the amount(s) shown above. I understand that:

- Cafeteria Plan Advisors, Inc. will hold these funds until eligible expenses are incurred and a claim is submitted. Funds may be forfeited in accordance with IRS Publication 969 if eligible expenses are not submitted for reimbursement by plan year deadline or purchased utilizing the provided debit card (if applicable). If terminated, expenses may be incurred through termination date.
- Dependents must qualify under regulations set forth in IRC sections 152 and 129.
- Expenses generally must be consistent with allowable medical deductions under IRS Publication 969.
- This election cannot be revoked or changed during the plan year without a qualifying event as defined by the IRS and must be incurred during active employment.
- If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for the FSA Health Care Account.
- **Participants must re-enroll each plan year.** Your plan has the Roll Over option. Eligible balances will roll over to the subsequent plan year for availability "after" the current plan run out period of 90 days. You must enroll in the subsequent plan year to utilize roll over funds.
- **Dependent Care Plan Participants only:** I, the undersigned, certify that I have read the Dependent Care Reimbursement Plan Guidelines ([www.cpa125.com](http://www.cpa125.com)) and meet all requirements necessary to participate in the FSA Dependent Care plan. The undersigned agrees to notify the plan administrator in writing within 30 days should the undersigned no longer meet eligibility as mandated by the IRS. Dependents must qualify under IRC section 152.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Return to your HR/ Payroll Department within 30 days of the qualifying event