Cafeteria Plan Advisors, Inc.
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NEW HIRE/ CHANGE IN STATUS
FLEXIBLE SPENDING PRE-TAX PAYROLL REDUCTION

Form must be returned to HR

☐ **New Hire or** ☐ **Change**

HR Use Only
First Payroll Deduction Date_____
Per Pay Period Amount $_____

Personal Information

Name: ***Employer:***

Street: ***Plan Year:***

City, ST, Zip: ***SSN:***

E-Mail: ***Phone:***

Payroll Information

I am paid: Weekly: ☐ Bi-Weekly: ☐ Semi-Monthly: ☐ Monthly: ☐ Other: _____

IF APPLICABLE: I am a: Municipal Employee ☐ School Employee ☐

Benefits Elected

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

☐ New Hire ☐ Marriage ☐ Divorce ☐ Birth/ Adoption ☐ Return from LOA ☐ Other

Date of Qualified Change _____

New benefit elections:

☐ FSA Medical/Dental Care Account ($2,500 maximum) **Original $** _____ **New $** _____

☐ FSA Dependent Care Account ($5,000 maximum) **Original $** _____ **New $** _____

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**

Check 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 must be consistent with allowable medical deductions under IRS Publication 969.
- **Dependent Care Plan Participants only**: I, the undersigned, certify that I have read the Dependent Care Reimbursement Plan Guidelines (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 Cafeteria Plan Advisors, Inc. via Fax, 781-848-8477 or email as a .pdf to info@cpa125.com