

Cafeteria Plan Advisors  
An Alera Group Company  
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Norwell, MA 02061  
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## NEW HIRE/ CHANGE IN STATUS FLEXIBLE SPENDING PRE-TAX PAYROLL REDUCTION

### HR Use Only

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

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

### RETURN TO HR/PAYROLL

**Participant Name:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Street:** \_\_\_\_\_ **Plan Year:** \_\_\_\_\_

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

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

### Payroll Information

I am paid: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other: (specify) \_\_\_\_\_

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

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

☐ New Hire ☐ Change Date of Qualified Change \_\_\_\_\_  
☐ Marriage ☐ Divorce ☐ Birth/ Adoption ☐ Return from LOA ☐ Other (Specify) \_\_\_\_\_

### New benefit elections:

☐ FSA Health Care Account (\$3,300 or plan max) Election for Remainder of Plan Year: \$ \_\_\_\_\_

☐ FSA Dependent Care Account (\$5,000 or plan max) Election for Remainder of Plan Year: \$ \_\_\_\_\_

### 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.
- If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for FSA Health Care Account.
- **Dependent Care Plan Participants only:** I, the undersigned, certify that I have read the Dependent Care Reimbursement Plan Guidelines (<https://getebm.com/spending-accounts>) 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.
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**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_