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/PAYROLL DEPT. WITHIN 30 DAYS OF HIRE/QUALIFYING EVENT**

## Personal Information

***Name:*** _____ ***Employer:*** _____

***Mailing Address:*** _____ ***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 ☐

***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 Medical/Dental Care Accounts ($2700 Maximum) Election for Remainder of Plan Year: $_____

☐ FSA Dependent Care Accounts ($5000 Maximum) Election for Remainder of Plan Year: $_____

☐ FSA Fee (if applicable) $_____

**FOR HR/PAYROLL DEPT USE ONLY:**

| MEDICAL | DEPENDENT CARE |
|---|---|
| First Payroll Deduction Date:_____ | First Payroll Deduction Date:_____ |
| Per Pay Period Amount: _____ | Per Pay Period Amount: _____ |

Fee Per Pay Period Amount:_____

Termination Date :_____ Final Check Date: _____

## 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:** _____