Cafeteria Plan Advisors, Inc.
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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:*** **City Of Everett**

Mailing Address: ***Plan Year:*** Date of Eligibility – 6/30/2019

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

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

Payroll Information

I am paid: Bi-Weekly 26: ☐ Teacher's Aides 20: ☐ Weekly 52: ☐

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 _________________

New Hire Date: ____________ Date of Qualified Change _________________

New benefit elections:

☐ FSA Health Care Account ($2,650 maximum) **Election for Remainder of Plan Year: $________**

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

☐ FSA Administrative Fee **$_______**

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.
- **Participants must re-enroll each plan year.**
- If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for the FSA Health Care Account.
- **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 your HR/ Payroll Department