

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:** **WINCHESTER**

Mailing Address: _____ **Plan Year:** _____ **THROUGH 12/31/20**

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 Marriage Divorce Birth/ Adoption Return from LOA Other _____

New Hire Date: _____ Date of Qualified Change _____

New benefit elections:

FSA Health Care Account (\$2,700 or Plan maximum)

New Election for the Plan Year: \$ _____

FSA Dependent Care Account (\$5,000 maximum)

New Election for the Plan Year: \$ _____

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.
- 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 (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:** _____