Cafeteria Plan Advisors, Inc.
420 Washington St. Suite 100
Braintree, MA 02184
Phone 781.848.9848
www.CPA125.com
Email: info@cpa125.com
Fax 781.848.8477

COVID RELIEF/ CHANGE IN STATUS
FLEXIBLE SPENDING PRE-TAX PAYROLL REDUCTION

FORM MUST BE RETURNED TO HR/PAYROLL DEPT. BY 6/30/2021

Name: ***Employer: CITY OF NEWTON***

Mailing Address: ***Plan Year: 1/1/2021-12/31/2021***

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

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

Payroll Information:

I am paid: Weekly: ☐ Semi-Monthly 24: ☐ Semi-Monthly 20: ☐ Other: _____

Employee Number:_____

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:** ☐ **COVID RELIEF**

New benefit elections:

☐ FSA Health Care Accounts ($2,750 Maximum) Election for Remainder of Plan Year: $_____

☐ FSA Dependent Care Accounts ($10,500 Maximum) Election for Remainder of Plan Year: $_____

FOR HR/PAYROLL DEPT USE ONLY:

HEALTH CARE

First Payroll Deduction Date:_____

Per Pay Period Amount: _____

DEPENDENT CARE

First Payroll Deduction Date:_____

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.
- 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:**