

Cafeteria Plan Advisors, Inc.
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AUTHORIZATION FOR PRE-TAX PAYROLL REDUCTION

Form must be returned to Cafeteria Plan Advisors.

11/30/16

This is a generic enrollment form. See your Human Resources department or contact Cafeteria Plan Advisors for actual plan specs.

Personal Information

Participant Name:

Employer: Town of Norton

Mailing Address:

Plan Year: 01/01/17-12/31/17

City, ST, Zip:

SSN:

DOB:

E-Mail:

Phone:

Payroll Information

I am paid:

Bi-Weekly: ☐

☐ FSA Dependent/ Day Care Account

I elect to contribute \$ _____ for the Plan Year.
(up to \$5,000 IRS maximum)

Confirm eligibility criteria prior to enrolling.

☐ FSA Health Care Account

I elect to contribute \$ _____ for the Plan Year.
(up to the \$2,550 IRS maximum or your employer's plan maximum if lower)

FSA Debit Card included

\$500 Rollover option in effect for this plan for unused balances

If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for the FSA Health Care Account.

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.
- This election cannot be revoked or changed during the plan year without a qualifying event as defined by the IRS.
- **Current participants must re-enroll each plan year.**
- **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.
- It is suggested you consult with a tax advisor since your participation will limit your ability to claim on your IRS taxes.
- **If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for FSA Health Care Account.**

Signature:

Date: