



CAFETERIA PLAN ADVISORS
 120 Longwater Dr., Suite 102
 Norwell, MA 02061
 Tel.: 781-848-9848

Authorization for Pre-Tax Payroll Reduction

Enrollment Deadline is 4/30/2024.

*** Late Enrollments not Accepted. ***

INSTRUCTIONS: Complete & return this form to **Benefits Coordinator, Room 114**, by the deadline date shown above.

1 Personal Information:

Participant Name: _____

Employer: **Town of Walpole**

Mailing Address: _____

TOWN Plan Year: **7/1/2024 to 6/30/2025**

City/Town, State: _____ **ZIP:** _____

SCHOOL Plan Year: **9/1/2024 to 8/31/2025**

(for expenses incurred during the plan year, plus 60-day grace period for Health Care FSA)

E-Mail: _____

Date of Birth: _____ **SSN:** _____

Daytime Phone: _____

personal
 work

2 I work for (check one): Town (deductions over 50 pay periods) Schools (deductions over 20 pay periods; Sept. 2024 to June 2025 payroll check)

Division (write in): _____

3 Flexible Spending Account (FSA) Benefit Selections:

Health Care FSA Election: \$_____ for the plan year for employee, legal spouse, and eligible dependents' qualified medical, dental, vision expenses. *Benefit card included.*

Max. Annual Election: \$3,200.

Ineligibility Note: You are NOT eligible for this plan if you or your spouse have a Health Savings Account ("HSA").

Dependent Care FSA Election: \$_____ for the plan year for qualified **day care** expenses for eligible dependents (as defined by the IRS) under age 13, elderly dependents, and dependents with special needs.

Max. Annual Election: \$5,000. per family

Claim-based plan; no benefit card. Participants must submit claim(s) each plan year to receive accrued funds.

See Open Enrollment flyer for more plan information.

4 Certification. I hereby authorize a salary reduction agreement for the amount(s) shown above and understand that:

- Cafeteria Plan Advisors will hold these funds until eligible expenses are incurred and a claim is submitted. Funds may be forfeited in accordance with Internal Revenue Service (IRS) Publication 969 if eligible expenses are not spent or submitted for reimbursement by plan year deadline or purchased utilizing the provided debit card within the plan year or the date upon which employment ends, whichever comes first.
- All claims for the Plan Year must be submitted within ninety (90) days of the end of the Plan Year.
- **This election cannot be revoked or changed** during the plan year unless the participant experiences a qualifying event as defined by the IRS.
- **Current participants must enroll each plan year; re-enrollment is not automatic.**
- **Health Care FSA cards**, if offered through your employer's plan, **will reload** at the start of each plan year when you re-enroll; keep until they expire.
- Additional certification for Dependent Care Plan Participants: I understand that the Dependent Care Reimbursement Plan Guidelines can be found at CPA125.com and I qualify to participate in the FSA Dependent Care plan. I agree to notify the plan administrator in writing within 30 days should I experience a change in need or no longer meet the IRS's eligibility criteria. Dependents must qualify under regulations set forth in IRC sections 152 and 129.
- Failure to return this signed form to the Benefits Coordinator by the deadline will result in termination from the plan.
- If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are **NOT ELIGIBLE** to participate in the Health Care FSA plan.
- Tax advice: It is suggested you consult with a tax advisor to determine your tax savings and/or limits on tax deductions.

➤ **Signature:** _____

Date: _____

A system-generated e-mail confirmation will be sent once your enrollment is processed.