Cafeteria Plan Advisors
An Alera Group Company
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NEW HIRE/ CHANGE IN STATUS
FLEXIBLE SPENDING PRE-TAX PAYROLL REDUCTION

FORM MUST BE RETURNED TO CAFETERIA PLAN ADVISORS WITHIN 30 DAYS OF HIRE/QUALIFYING EVENT

Name: ***Employer: CITY OF BOSTON***

Mailing Address: ***Plan Year: _____- 12/31/2025***
(Fill in above: date of hire or event date)**

City, State: ***Zip:*** ***SSN:*** ***(must provide if new hire)***

E-Mail: ***Phone:*** ****Employee ID #*** ***D.O.B:***

Payroll Information **I am paid:** ☐ Weekly 52 ☐ Bi-Weekly 26

☐ Bi-Weekly 21 (school employees that do not receive payroll check over the summer)

IF APPLICABLE: I am a: ☐ Municipal Employee ☐ School Dept. 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:_____**

New benefit elections:

☐ FSA Health Care Accounts ($3300 or Plan Maximum) Election for Remainder of Plan Year: $_____
☐ FSA Dependent Care Accounts ($5,000 Maximum) Election for Remainder of Plan Year: $_____
☐ Transit ($325/month = $3,900/year Maximum) Election for Remainder of Plan Year: $_____
☐ Parking ($325/month = $3,900/year Maximum) Election for Remainder of Plan Year: $_____

CPA/PAYROLL DEPT USE ONLY:

HEALTH CARE
First Payroll Deduction Date:_____
Per Pay Period Amount: _____

DEPENDENT CARE
First Payroll Deduction Date:_____
Per Pay Period Amount: _____

PARKING
First Payroll Deduction Date:_____
Per Pay Period Amount:_____

TRANSIT
First Payroll Deduction Date:_____
Per Pay Period Amount:_____

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:**