

Cafeteria Plan Advisors, Inc.
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Braintree, MA 02184
Phone 781.848.9848
www.CPA125.com
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AUTHORIZATION FOR PRE-TAX PAYROLL REDUCTION

Form must be returned to Cafeteria Plan Advisors by: 12/27/2016

Current participants can enroll online.

Go to www.cpa125.com and click on Employee Online Access.

Personal Information

Name:

Employer:

VICTORY PROGRAMS

Mailing Address:

Plan Year:

1/1/2017 – 12/31/2017

City, ST, Zip:

SSN:

DOB:

E-Mail:

Phone:

Payroll Information

I am paid: Bi-Weekly: ☐

Benefits Selected

☐ **FSA Dependent/ Day Care Account**

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

Confirm eligibility criteria prior to enrolling.

☐ **FSA Health Care Account**

I elect to contribute \$ _____ for the Plan Year.
(\$2,600 maximum)

Includes Benny card

\$500 Roll Over option in effect for this plan year for available balance

☐ **Parking Reimbursement**

I elect to contribute \$ _____ for the Plan Year.
(\$255 maximum per month; \$3,060 annual max)

☐ **Transit Reimbursement**

I elect to contribute \$ _____ for the Plan Year.
(\$130 maximum per month; \$1,560 annual max)

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

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 and be incurred during your active employment.
- If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for the FSA Health Care Account.
- This election cannot be revoked or changed during the plan year without a qualifying event as defined by the IRS.
- **Participants must re-enroll each plan year.** Your plan has the Roll Over option. Eligible balances will roll over to the subsequent plan year for availability "after" the current plan run out period of 90 days. You must enroll in the subsequent plan year to utilize roll over funds.
- **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: