

CPA, Inc.
420 Washington St. Suite 100
Braintree, MA 02184
781.848.9848 (Phone)
www.CPA125.com

AUTHORIZATION FOR PRE-TAX PAYROLL REDUCTION

SIGNED FORM MUST BE RETURNED BY:

781.848.8477 (Fax)

Name

Street

City, State, Zip

E-Mail Address:

Employer: _____

Plan Year: _____
(expenses must be incurred between these dates)

SSN: _____

Phone: _____

I am a: Municipal Employee School Employee Department/Location: _____

I am paid: Weekly Bi-Weekly 26 Bi-Weekly 21 Semi-Monthly Monthly Other: _____

Benefits Selected:

FSA Dependent Care Account/Daycare (\$5,000 maximum) I elect to contribute \$ _____ for the Plan Year.
(requires dependent care certification form – available online)

FSA Medical/Dental Care Account (\$ plan maximum) I elect to contribute \$ _____ for the Plan Year.
(does not include insurance premiums)

FSA Administrative Fee: _____ \$ _____ for the Plan Year.

Direct Deposit Information: (REQUIRED, unless already on file with CPA, 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. I will contact CPA, Inc. immediately with any bank information changes.

Name of Bank: _____ Checking Savings

Routing Number (9 digits): _____ Account Number: _____

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

- This election cannot be revoked or changed during the plan year without a qualifying event as defined in the IRS regulations.
- Dependents must qualify under regulations set forth by the IRS.
- Services must be consistent with allowable medical deductions under the IRS Code.
- Failure to return this signed form to CPA, Inc. by the deadline will result in termination from the plan.

Signature: _____ Date: _____

Note: Effective 1/1/2011, over-the-counter medicines will no longer be an eligible expense per the Health Care Reform Act.