ebm (formerly Cafeteria Plan Advisors)
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NEW HIRE/CHANGE IN STATUS
FLEXIBLE SPENDING PRE-TAX PAYROLL REDUCTION

HR Use Only
First Payroll Deduction Date: _________
Per Pay Period Amount: $____________

RETURN TO HR/PAYROLL

Participant Name: ***Employer: Town of Chelmsford***

Street: ***Plan Year:** **Date of Hire/Event Date _________ thru 6/30/2027***

City, State ***Zip:*** ***SSN:*** ***D.O.B.***

E-Mail: ***Phone:***

Payroll Information: **I am paid:** ☐Bi-Weekly 26 ☐Bi-Weekly 21

The following qualified change in election for the Cafeteria Plan is the result of one of the following:

☐ **New Hire** ☐ **Change** **Date of Qualified Change** _________________

☐Marriage ☐Divorce ☐Birth/ Adoption ☐Return from ☐LOA ☐Other (Specify) _________________

New benefit elections:

☐ FSA Health Care Account ($3,400 or plan max) **Election for Remainder of Plan Year: $____________**

☐ FSA Dependent Care Account ($7,500 or plan max) **Election for Remainder of Plan Year: $____________**

Certification

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

- The spending account administrator 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) within the plan year or the date upon which employment ends, whichever occurs first.**
- 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 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:**