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Authorization for Pre-Tax Payroll Reduction

*** Open Enrollment. The Deadline to Enroll is 6/8/2026. ***

INSTRUCTIONS: **Enroll Online:** **1)** Go to **cpaemployee.lh1ondemand.com**. **2)** On the right side of the sign-in page, enter code **CAF-0428** (the 5th character is a zero) and set up your account—*be sure to include your Soc. Sec. number and all contact info.!* **3)** Once on your account home page, click the blue *ENROLL/RE-ENROLL* button near the top of the page and follow the steps to enroll for the new plan year. **4)** At the end of the enrollment process, be sure to click *Submit*. Note: We suggest printing or saving your enrollment confirmation message.

or Complete & return this form to **Nick George**, Treasurer/Collector; e-mail: ngeorge@rutlandma.gov.

❶ Personal Information:

Participant Name: _____ **Employer:** **Central Massachusetts Regional 911 District**

Mailing Address: _____ **Plan Year:** **7/1/2026 to 6/30/2027**
(Expenses must be incurred between these dates)

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

☐ personal

E-Mail: _____ **Daytime Phone:** _____ ☐ work

❷ Flexible Spending Account (FSA) Benefit Selections:

☐ **Health Care FSA Election: $_____ for the plan year** for qualified, non-cosmetic medical, dental and vision expenses for you, your legal spouse (if married), your eligible dependents (as defined by the IRS), and your adult children under age 26. *Benefit card included.*

Max. Annual Election: $3,400.

★ ***Employer Contribution:*** *Town of Rutland will contribute* ***an additional $500*** *to your Health Care FSA election amount if you enroll for at least $500.*

Rollover Option: An unused balance of up to $680 can roll over to the next plan year as long as you re-enroll.

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 your eligible dependents (as defined by the IRS) **under age 13**, elderly dependents, and dependents with special needs who are named on your tax return.

Max. Annual Election: $7,500 per family.

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

See Open Enrollment flyer for other important plan info.

The annual FSA admin. fee is paid by your employer.

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

- ebm 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.
- FSA expenses must be consistent with allowable deductions under IRS Publication 969.
- **This election cannot be revoked or changed** during the plan year unless the participant experiences a qualifying event as defined by the IRS.
- **Participants must actively enroll/re-enroll for each plan year; re-enrollment is not automatic.**
- All claims for eligible expenses incurred during the Plan Year and paid for out-of-pocket (not using benefit card) must be submitted for reimbursement within ninety (90) days following the end of the Plan Year.
- Your Health Care FSA plan has a **Rollover option**. Eligible balances as noted above can roll over to the next plan year when you re-enroll in the Health Care FSA for the new plan year and the rollover occurs after the current plan year's 90-day claim submission ("runout") period has closed.
- **Health Care FSA cards** can reload at the start of each new plan year for which you have re-enrolled; add'l & replacement cards available for nominal fee.
- 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.
- **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.