



Spending & Commuter Benefits Renewal Form

Submit the completed form by one of the following methods:	Online Support	Mail
	Email to cpisupport@mycpiteam.com . If you have questions on your current plan, you can login to your portal to review.	CPI, 6421 Perkins Rd., Bldg. A, Suite 2A, Baton Rouge, LA 70808

CLIENT/EMPLOYER INFORMATION

Client/Employer Name:			
Primary Contact:			
Email:			Phone Number:
Address:	Address 1:		
	Address 2:		
	City:		
	State:	Zip Code:	

PLAN CHANGES

Plan Year Start Date:		Plan Year End Date:		Total Employee Count:	
Renew my FSA and/or Commuter Plans:					
With NO changes. (if no other changes, move to bottom of page 2)			With the changes indicated below. Effective Date:		
Only Change IRS Maximum (If no other changes, move to bottom of page 2)			<i>If changes are required, please make selections and complete the required information below.</i>		

Change in Payroll Schedule <i>(Any changes REQUIRE the Payroll Frequency and Payroll Dates sections to be completed. Please include a copy of your payroll schedule. Please make sure to note which dates do not have benefit deductions.)</i>			
Payroll Frequency:	Weekly	Biweekly (24)	Biweekly (26)
	Semi-Monthly	Monthly	Other
Payroll Dates: <small>(Format: MM/DD/YYYY)</small>	1st Payroll Date (of plan year):	2nd Payroll Date:	Last Payroll Date:
Change in Employer Contribution Schedule			
Employer Contribution Posting Frequency:	Payroll Schedule (As per above Payroll Dates)	Annual Schedule	User Initialized
	Custom Schedule (Enter posting frequency):		
CONTINUED ON PAGE 2			



Spending & Commuter Benefits Renewal Form

Change in Plan Elections			
	Plan Minimum	Plan Maximum	Employer Contribution Maximum
Healthcare FSA (HFSA):	\$	\$	\$
Limited Purpose Healthcare FSA (LPFSA):	\$	\$	\$
Dependent Care FSA (DCA):	\$	\$	\$
Transit Account (monthly limits):	\$	\$	\$
Parking Account (monthly limits):	\$	\$	\$
Change in Plan Runout, Grace Period, Carryover, or Rollover			
Runout Period:	# of days from plan year end:	Grace Period: <i>(up to 2 months and 15 days)</i>	# of mo/days:
Grace Period: <i>(Not available for plans with Carryover)</i>	Healthcare FSA	Limited Purpose Healthcare FSA	Remove from plan
	Dependent Care FSA		
Carryover: <i>(year to year)</i>	Amount \$	Healthcare FSA	Remove from plan
		Limited Purpose Healthcare FSA	
Rollover: <i>(month to month)</i>	Transit	Parking	Remove from plan
Change in Plan Year:	Plan Start Date:	Plan End Date:	
Loss of Eligibility: (status changes to terminated, retired or LOA)	<ul style="list-style-type: none"> • Allow claims to be filed iwth a date of service after ineligible • Allow ineligible participants to file claims for: _____ days following the 		
Additional Notes:			

Signature and Additional Items Needed

Payroll Schedule - Please send payroll schedule for this coming plan year.
Enrollments - Enrollments for new plan year:
File Feed Employer Portal Demographic Template or Enrollment Form
Signature: _____ Date: _____