



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 other than IRS maximum limits.
If no other changes, move to bottom of page 2.

☐ With the changes indicated below.
 Effective Date: _____
If changes are required, please make selections and complete the required information below.

☐ Change in Payroll Schedule (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.)			
Payroll Frequency:	☐ Weekly	☐ Biweekly (24)	☐ Biweekly (26)
	☐ Semi-Monthly	☐ Monthly	☐ Other _____
Payroll Dates: (Format: MM/DD/YYYY)	1 st Payroll Date (of plan year):	2 nd 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: (up to 2 months and 15 days)	# of mo/days:
Grace Period: (Not available for plans with Carryover)	☐ Healthcare FSA	☐ Limited Purpose Healthcare FSA	☐ Remove from plan
	☐ Dependent Care FSA		
Carryover: (year to year)	☐ Amount \$	☐ Healthcare FSA	☐ Remove from plan
		☐ Limited Purpose Healthcare FSA	
Rollover: (month to month)	☐ 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)		• Allow claims to be filed with 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: ☐ Demographic Template or Enrollment Form
☐	Employer Portal ☐ File Feed - if choosing file feed, please include contact information
	Name Email Address
Signature:	
Date:	