Flexible Spending Account (FSA) Enrollment Form

Lifetime Benefit Solutions

Employer Name: _____

Participant Name (First, MI, Last): _____

Social Security Number: _____ Phone Number: _____

Address: _____

City, ST, ZIP: _____

Date of Birth: _____ Date of Hire: _____

E-mail Address: _____

☐ I agree to receive communications regarding my FSA via email from Lifetime Benefit Solutions (LBS).

FSA Benefit Election	Total Annual Amount	Maximums
☐ Health Care Election - Standard	$	$3,500
☐ Dependent Care Election	$	$7,500
☐ Parking Election	$	$4,200
☐ Transit Election	$	$4,200

Carrier Information

If you are eligible for Automatic Claims Transfer (ACT) (check with your employer), certain expenses submitted through your insurance provider may automatically be reimbursed to you, unless you or any of your dependents have Coordination of Benefits (COB) with other Plans. This feature is not applicable to Health Spending Card holders.

☐ I do not want ACT or I have COB and am not eligible for Automatic Claims Transfer (ACT).

Spouse/Dependent Information (attach additional pages if necessary) ☐ I do not have a spouse or dependents

Name	Social Security No.	Date of Birth	Gender	Relationship

Enroll In Direct Deposit

To sign up for direct deposit, please log into the LBS consumer portal at **LifetimeBenefitSolutions.com/start**.

Your personalized consumer portal will be available to access on or after your effective date. Upon entering your bank account information, there will be a verification process to complete activation of your direct deposit. Your direct deposit will not be active until the micro-deposit is verified.

Participant Authorization (Return signed form to your employer)

By signing below, I agree to participate in my employer's pre-tax program and certify that I understand and will comply with the regulations governing such Plan. I understand the basic provisions provided on page 2 of this form are guidelines only and that my Plan's Summary Plan Descriptions prevails.

Participant Signature: _____ Date: _____

To Be Completed by the Employer

☐ New Hire ☐ Open Enrollment

Effective Date: _____

First Payroll Deduction Date: _____

- Notify Payroll of deduction amount and date
- Keep copy of Enrollment Form for your records
- Forward copy of Enrollment Form or provide data on a file to LBS

This Plan has employer funded money: ☐ Yes ☐ No

If Yes:

Employer Money	Payroll Based?	Annual Amount
☐ Medical Care	☐ Yes ☐ No	$
☐ Dependent Care	☐ Yes ☐ No	$

Direct Deposit:

Direct Deposit sends claim reimbursement payments directly to your personal bank account. Direct Deposit notification statements will be emailed to you with details of the reimbursement. If you provide incorrect information and corrective transactions are required, your account may be charged a $25 processing fee. Direct Deposit transactions are not subject to the typically imposed $30 check minimum.

Things to Consider Upon Enrollment:

- Your FSA account refers to the combined medical care and dependent care components.
- By enrolling in the FSA program, you agree to have your compensation reduced by the amount elected.
- Your election applies to this Plan year only. To continue in the Plan, you must re-enroll each year.
- Annual medical care elections are available for reimbursement in fuII on the first day of the Plan year.
- Dependent care elections are available for reimbursement based on current balance.
- FSA accounts are tracked separately and cannot be combined. These elections are in addition to any premiums you pay on a pre-tax basis for employer-sponsored health insurance.
- The dependent care account pays for daycare services needed for a qualifying dependent while you work. A qualifying dependent is a child under age 13 who is claimed as a dependent on your federal income tax return (special rules apply for divorced parents), a disabled spouse, and any other dependent on your tax return who resides in your home and is physically or mentally disabled.
- You may file claims for reimbursement from your FSA account for qualified expenses incurred during the Plan year, after becoming a participant. Depending on the provisions in your Plan, some or all of the funds remaining in your FSA account after the end of the Plan's run-out period may be forfeited.
- You will pay the Employer for any tax liability or penalties it incurs if you are reimbursed for an expense that is not a qualified expense, unless you repay the amount or offset that amount with additional eligible claims within the same Plan year.
- You cannot change the amount of your FSA contributions or pre-tax health insurance premiums, unless you have a qualifying "life change" event as defined in the Plan, and satisfy any other conditions for changes contained in the Plan and tax law.
- Your FSA contributions will terminate when your employment terminates. You must check with your Employer to determine if you can elect to continue your health care contributions on an after-tax basis, as allowed under COBRA.
- Your employer may change the amount of your FSA elections, if necessary to satisfy tax law requirements.
- You must provide acceptable documentation for every claim you submit, including Health Spending Card purchases, upon request.
- You will keep copies of all documents submitted to Lifetime Benefit Solutions for your own personal records; Lifetime Benefit Solutions is not responsible for retaining copies of your receipts beyond the current Plan year.
- Flexible Spending Accounts and Health Reimbursement Accounts are subject to Federal Law which generally supersedes state law.
- Only spouses and dependents for Federal Tax purposes are eligible for tax-free Flexible Spending Accounts and Health Reimbursement Accounts benefits.
- Any person who qualifies as your dependent for federal income tax purposes, or your child even if he or she does not qualify as your dependent for federal income tax purposes but only through the end of the calendar year in which the child reaches age 26.