Lively

# Flexible Spending Account Enrollment Form

## Employee Information

Employer name

First name

Last name

Social security number

Date of birth

Phone number

Marital status

Email

Home address (cannot be PO Box)

City

State

Zip code

Mailing address (if different from home address)

City

State

Zip code

## Enrollment Information

☐ I decline to participate in a Flexible Spending Account (FSA)

☐ I elect to participate in the following:

☐ **General Purpose (Medical) FSA**

*Covers eligible out-of-pocket healthcare expenses not covered by your health plan. If you or your spouse has a Health Saving Account (HSA) you cannot make contributions to the HSA while you are covered under this FSA.*

Amount per pay period (optional) x Number of pay periods (optional) = Annual election amount

☐ **Limited Purpose FSA**

*Covers eligible dental, vision, and post-deductible healthcare expenses. You cannot participate in this account if you participate in a Medical FSA. You can contribute to this account while making contributions to an HSA.*

Amount per pay period (optional) x Number of pay periods (optional) = Annual election amount

☐ **Dependent Care FSA**

*Covers eligible out-of-pocket day care or elder care expenses.*

Amount per pay period (optional) x Number of pay periods (optional) = Annual election amount

**Acknowledgment:** I make this election under my employer's Cafeteria Plan, administered consistent with IRC Sec. 125. By making this election, I authorize my employer to reduce my taxable compensation in order to fund my Flexible Spending Account(s). This reduction will be made in equal installments over the course of the Plan Year. I understand this election is legally binding and cannot be revoked or updated during the Plan Year, except under special enrollment circumstances prescribed under the law and described in the Summary Plan Description (SPD), and will otherwise be possible for future Plan Years based on the law and as applied by the policies set forth in the SPD. I understand that unused amounts at the end of the Plan Year may be forfeited. Contact your administrator for more details or any questions.

**Employer name**

(Type of print name)

**Date**

/ /

**Please return the completed form to your HR administrator.**

## For Employer Use

**Date of hire**

/ /

**FSA effective date**

/ /

**Department/division (if applicable)**

**Payroll frequency**

**FSA payroll contribution start date**

/ /