Flexible Spending Account (FSA) enrollment form

Lifetime Benefit Solutions

Employer name: Town of Webster

Participant name (First, MI, Last): _____

Social Security number: _____ Phone number: _____

Address: _____

City, ST, ZIP: NY _____

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	Per pay period amount	Total annual amount	# Pays per year
☐ Medical/Health FSA	$	$ 0.00	26
☐ Dependent Care FSA	$	$ 0.00	26
☐ Limited Purpose FSA	$	$ 0.00	26

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
			Select	
			Select	
			Select	

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	$