Flexible Spending Account (FSA) Enrollment Form

January 1 – December 31, 2021

Employee Information				
Employee Last Name:	First Name:	MI:	Gender:	Marital Status: ☐ Single ☐ Married
Last 4 SSN:	Date of Birth:		Phone Number:	
Mailing address: (street, city, state, zip code)				
Effective Date: 01/01/2021	Hire Date:		Plan Year: 01/01/2021 – 12/31/2021	
E-mail Address:				

☐ I decline all FSA Elections at this time.

FSA Elections	Yes/No	Annual Election	# of Paychecks	Paycheck Deduction
General Purpose Health FSA* Maximum of $2,750 per plan year If you or your spouse participate or plan to participate in a Health Savings Account (HSA), you are ineligible to participate in a general-purpose health FSA.	☐ Yes ☐ No	$ _____	_____	$ _____
Limited Purpose Health FSA* Maximum of $2,750 per plan year Option for Health Savings Account (HSA) participants. The limited purpose health FSA only reimburses dental and vision care expenses.	☐ Yes ☐ No	$ _____	_____	$ _____
Day Care FSA Maximum of $5,000 per plan year (or $2,500 if you're married and filing taxes separately)	☐ Yes ☐ No	$ _____	_____	$ _____

*The $2,750 health FSA limit is aggregate. If Lakeside is putting your wellness incentive in a limited purpose FSA (because you are not eligible for the HSA), that contribution counts towards your $2,750 health FSA limit.

Signature

There may be limits on the amounts which can be used for certain benefits. You should review your Summary Plan Description and ask your Plan Administrator if you have any questions. With regard to my salary reduction agreement and my election of benefits, I understand that:

- I may not change the election during the Plan Year unless there is a change in my family status (e.g. termination of employment or change to part time status by either myself or my spouse, marriage, divorce, death of my spouse or child, adoption or birth of my child) if the change is allowed by my Flex Plan Document.
- My employer and I agree that my compensation will be reduced by the amounts set forth above for each pay period during the plan year (or during such portion of the year as remains after the date of this agreement).
- The Plan Administrator is authorized to adjust the amount of my salary reduction and benefits, if it is necessary to satisfy certain provisions of the Internal Revenue Code or as a result of changes in premiums for benefits that are insured.
- My election of salary reduction and benefits will remain in effect only for the plan year for which these elections are made. Failure to sign a new election form during the election period prior to each subsequent Plan Year will be considered an election not to participate in the Plan for that plan year.
- My Social Security benefits may be reduced as a result of my election.
- I understand and agree that this agreement is: 1) subject to the terms of the company's Cafeteria Plan, Health Flexible Spending Account, and/or Dependent Care Assistance Plan as amended from time to time; 2) shall be governed by and construed in accordance with applicable laws; 3) shall take effect under applicable laws; and 4) revokes any prior election and compensation reduction agreement relating to such plan(s).

SIGNATURE AND DATE

☐ By checking this box and typing my name below, it is my intent to electronically sign and electronically submit this form. I understand that by checking this box and typing my name below, I will be applying my electronic signature to this form and that I will be bound with the same force and effect as if I had signed this form on paper by hand.

_____ _____

Employee Name Date