

## Out-of-Scope Flexible Spending Plan Annual Reallocation Form

### PLAN MEMBER INFORMATION

First Name:	Last Name:	Benefit ID/ Person ID:	
Mailing Address:	City:	Province:	Postal Code:
Date of Birth: <small>mm/dd/yyyy</small>	Home Telephone:	Work Telephone:	
Email Address:			

### ALLOCATING YOUR ANNUAL CREDITS

- A. I acknowledge that I have read the printed materials and fully understand that:
- a. Once my selection is made, it cannot be changed or altered until the next annual re-enrolment period.
  - b. There may be tax implications associated with my selection and that it is my responsibility to speak with a tax advisor so that I can make an informed decision.
  - c. If I do not make an allocation in writing by the specified date on my letter that my 2025 annual selection will remain the same as my previous account selection on file.
  - d. Under the Lifestyles Spending Account (LSA) that any unused funds at December 31st of each year will be forfeited. No amount of unused funds or expenses may be carried over.
  - e. Under the Health Spending Account (HSA) that I may carry over my credits for a period of one calendar year only. Any unused credits from the previous year must be used by the end of the next calendar year or they will be forfeited.
  - f. The claim submission deadline is February 28, 2025.
- B. I authorize and direct that my annual credits be allocated as follows:
- 100% of my annual allocation be applied to the Health Spending Account (HSA)
- 100% of my annual allocation be applied to the Lifestyles Spending Account (LSA)
- 50% of my annual allocation be applied to the Health Spending Account (HSA) and 50% of my annual allocation be applied to the Lifestyles Spending Account (LSA)

### SIGNATURE

I hereby acknowledge that I have read and understand the conditions of the Out-of-Scope Flexible Spending Plan, as outlined in the Plan commentary and confirm the options I have chosen above. I understand these benefits are subject to the terms of the Out-of-Scope Flexible Spending Plan, as applicable, administrated by Health Shared Services Saskatchewan (3sHealth).

By signing this form, I agree that the information provided is complete and accurate.

Your Signature:	Date: <small>mm/dd/yyyy</small>
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