3sHealth – Employee Benefits
600-1919 Saskatchewan Drive, Regina, SK S4P 4H2
T. 306-347-5519 F. 306-347-5910
Toll Free: 1-866-278-2301
Email: ebp@3sHealth.ca

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: mm/dd/yyyy	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: mm/dd/yyyy

3sHealth Employee Benefits is committed to protecting the privacy of your personal information. We collect and use your personal information to determine your eligibility for coverage and to administer the benefit plans. We limit access to your personal information to 3sHealth Employee Benefits staff, to any third party authorized by 3sHealth who requires it to administer your benefits, to persons whom you have granted access, and to persons authorized by law.

SUBMIT BY EMAIL