



# FLEXIBLE SPENDING ACCOUNT BALANCE FORFEITURE FORM

If you are enrolled in a Health Care Flexible Spending Account (Health Care FSA) and have a cash balance in your account, you may not enroll in a Health Savings Account (HSA). If you want to enroll in a HSA in the upcoming Plan Year, your Health Care FSA's cash balance must be \$0 at the end of the last day of the then-current Plan Year. Please complete this form to forfeit your Health Care FSA's remaining balance as of the last day of the then-current Plan Year so you may enroll in a HSA in the upcoming Plan Year.

## Member Information

\_\_\_\_\_  
Last Name, First Name, MI (Please Print)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
Home Address (if different)

\_\_\_\_\_  
City, State, ZIP

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Member Email

\_\_\_\_\_  
Employer/Company Name

HSA Effective Date: \_\_\_\_\_  
(Example: 1/1/2021)

Health Care FSA Plan Year: \_\_\_\_\_  
(Example: 1/1/2020 - 12/31/2020)

Current Health Care FSA Balance: \_\_\_\_\_

**Note:** Please list the exact balance of your Health Care FSA on the date you complete and sign this form.

## Health Care FSA Forfeiture Authorization

By signing this form, I authorize my employer and Surency to reduce my Health Care FSA cash balance to \$0 and treat all of my Health Care FSA funds as forfeited. I instruct my employer and Surency to adjust my Health Care FSA's remaining balance to \$0 as of the last day of the then-current Plan Year enabling me to enroll in a HSA in the upcoming Plan Year. I acknowledge that I am voluntarily reducing my Health Care FSA's remaining balance to \$0. I understand that forfeiting all of my Health Care FSA funds is permanent and may not be reversed. I certify that all information I provided on this form is accurate as of the date next to my signature below.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

*Please return this completed form to your Employer/HR Department.*

\_\_\_\_\_  
Employer/Company Representative Signature

\_\_\_\_\_  
Date

**Return completed form back to Surency at email: [flex@surency.com](mailto:flex@surency.com) - fax: 316-272-4841  
or mail: P.O. Box 789773, Wichita, KS 67278-9773**

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