Health Savings Account (HSA) Contribution Election Form

Name	Social Security #	E-Mail
Company	Location	
Home/Mailing Address	City	State / Zip
Home Phone	Work Phone	700 #
HDHP Insurance Coverage Selected:	Employee Only ☐	Family ☐

HSA Contribution Election Amount (Check One Box)

❑ **Accept** I elect to reduce my gross wages and contribute $___________ per pay period (include Benefit Dollars) into my HSA Trust Account at the Bank specified on my Trust Account Agreement. Once elected, this before-tax payment will continue indefinitely until I change my election amount by completing this form again.

❑ **Waive** I do not want to contribute through salary reductions into my HSA Trust Account at this time.

❑ **Catch-Up Election** I certify that I am (or will) attain age 55 during the current tax year and elect to reduce my gross wages and contribute an additional catch-up amount of $_____________ per pay period into my HSA Trust Account.

Purpose: This agreement is designed to allow an employee to convert a portion of his/her taxable earnings to a tax-free benefit status, pursuant to IRS Code Section 125 Plan and other code sections listed under a Flexible Benefit Plan. The Employer and Employee mutually agree to this election. It is a binding agreement effective _________ through __________. **Election changes are allowed during a Plan Year only as specified within the Flexible Benefit Plan Adoption Agreement.**

Limitations: The program will not affect any existing employee contract. All other benefits currently received by the employee shall continue unchanged. Termination of the employee's employment end this agreement.

Benefits: The non-taxable benefits offered by the Employer under this program include the HSA Trust Account contribution as specified above. I understand that I must be active in a qualifying High Deductible Health Plan (HDHP) at the beginning of each month in order to continue to be eligible to make contributions into the HSA Trust Account. If I no longer qualify to participate in the HSA plan then I must stop my contributions into the HSA Trust Account immediately. Dollars contributed to the HSA Trust Account are owned by me as the Account Holder. I may use these dollars tax-free for eligible medical expenses or use the dollars (subject to taxes and penalties) as explained under the HSA Trust Account rules as governed by the federal government. I understand the options available to me and choose the election above.

Certification: I understand that before I am eligible to make contributions to a HSA Trust Account: 1) I must be covered under a qualifying HDHP (as defined in Code Section 223(c)); 2) I cannot be claimed as another person's dependent; 3) I am not entitled to Medicare benefits; and 4) If I have any health coverage other than my coverage under the qualifying HDHP, that coverage is either qualifying HDHP coverage or permitted non-HDHP insurance or coverage. By signing this form and returning it to the Employer, I certify that all the statement are true. I understand that I am not eligible for HSA contributions during any month in which I do not meet all of the above HSA eligibility conditions and I agree that I will notify the Employer immediately in writing if I cease to meet any of these conditions. I also understand the the Employer will make contributions to an HSA Trust Account on my behalf on the basis of my certification and that the Employer's HSA contributions and my own HSA contributions are subject to certain aggregate limits under federal tax law.

Employee Signature ____ Date ___________________

Employer Signature ____ Date ___________________

****Plan Administrator/Coordinator Use Only**** ❑ Initial Election ❑ New-Hire Election Date of Hire _____________

❑ Election Change Date Change Request Received ______________________

Effective Date of Change ___________ # Pay Period Deductions ________

Approved By ____ Date Approved _____________

Employer must retain a copy for payroll and the employee