Health Savings Account Agreement Form

Print clearly and return this completed Agreement to Human Resources/Benefits Dept.

Employer Name			
Name (Last, First, MI)		**Social Security Number or ID Number**	
Street Address	**City**	**State**	**ZIP Code**
Effective Date of Election	**Type of Election**		**Date of Birth-MM/DD/YY**
	☐ New Election ☐ New Hire Election ☐ Change in Election ☐ Stop Election		

Health Savings Account Election
HSA Custodian – HSA Central

Per Pay Period Salary Reduction Amount	Indicate the Per Pay Period Amount that you wish to contribute to the HSA
Check the medical plan coverage tier that you have enrolled in. ☐ **Employee Only HDHP Coverage** ☐ **Family HDHP Coverage**	$ ______

I understand:

- I have elected to have pretax deductions from my pay based on the number of pay periods as set up by my employer during the plan year and that this election will continue until this Agreement is amended or terminated as allowed under the Plan.
- The HSA is an individually owned and managed account and that I am responsible to understand the HSA.
- My employer cannot provide tax advice or confirm that I meet the eligibility requirements for the HSA.
- I may obtain information about HSAs from a qualified tax professional or IRS Publication 969.
- Pretax deductions reduce my compensation for tax purposes which reduces my Social Security benefits.
- I am responsible to understand the eligibility requirements for contributions made to my HSA and by my signature below, state that I do qualify to make contributions to this account.
- I must assume responsibility for this individually managed account for:
  - Determining my eligibility for the HSA each year a contribution is made
  - Ensuring that all contributions made to my account are within the limits set forth by the tax laws
  - Any tax consequences related to contributions (including rollover contributions) and distributions
  - Keeping all documentation including insurance plan explanation of benefits forms and itemized receipts to support distributions taken from my account
  - Paying any associated banking fees that may be billed to me
- If married and electing family HDHP coverage, I certify that my spouse does not have any non-HDHP coverage.
- Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account.
- My employer may change my election if necessary in order to satisfy certain provisions of the Internal Revenue Code.
- My election and this Agreement will cease upon termination of employment.
- Expenses for which I claim a tax deduction under my income tax return cannot also be paid from my HSA.
- The Health Savings Account, and my rights and obligations under this HSA, as specified in the HSA materials.
- This Agreement cancels any prior election agreement I have made and cannot be changed except as stated in my employer's Plan.

I agree to notify my employer immediately if I experience any changes that would impact my eligibility to participate in an HSA.

Employee Signature ______________________________ **Date** ______________