HSA Participant Election Form/Salary Reduction Agreement

Please return this form to your Employer

Employer Name:		
Employee Name:		
Social Security Number:	DOB:	
Address:		
City:	State:	Zip:

Election of HSA Pre-Tax Benefits under the Employees Cafeteria Plan

Certification: By electing HSA Benefits, I am certifying that I meet the requirements under Internal Revenue Code § 223 to be eligible to contribute to an HSA. (For more information about HSA eligibility requirements, see IRS Publication 969.)

Important Information for Health FSA Participants: HSA Benefits cannot be elected in addition to Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option is selected. In addition, because the Health FSA includes a grace period, if you have an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option) that has an account balance on the last day of a Plan Year, you cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year. For more information about how Health FSA benefits can affect your eligibility to make HSA contributions (and your spouse's eligibility to do so, if you are married), see the Employees Cafeteria Plan Summary Plan Description (SPD).

Requirement to Provide HSA Information: Participants electing HSA Benefits must provide sufficient identifying information about the Participant's HSA to facilitate the forwarding of contributions through the Employer's payroll system to the Participant's designated HSA trustee/custodian.

☐ HSA Benefits: **$ _________/per pay.** Annual maximum is the statutory maximum for my High Deductible Health Plan (HDHP) coverage. (Note: Contact Compensation Consultants or the Payroll Department for current limits — an additional $1000 may he contributed if you are 55 or older).

AFFIDAVIT:

I have read and agree to the terms of participation and to any applicable certifications set forth in this Agreement. Any previous election and agreement under the Plan relating to the HSA Benefit, including any prior Election Form/Salary Reduction Agreement, is hereby revoked.

Employee Signature:	**Date:**