

HSA TRUST ACCOUNT CONTRIBUTION ELECTION FORM

Employee Name	Social Security #	Email
Company	Location	
Home/Mailing Address City State Zip		
Home Phone	Work Phone	
HDHP Insurance Coverage Selected: <input type="checkbox"/> Single <input type="checkbox"/> Family		

HSA Contribution Election Amount (Check One Box)

The HSA Trust Account funding per year is limited to the current federal limit. Individuals who attain age 55 during the tax year can make additional "catch-up" contributions into the HSA Trust Account each year. The additional catch-up value is \$1,000.

Employer Benefit Dollar Contribution is: _____

- Accept** I elect to reduce my gross wages and contribute \$ _____ per month (include Benefit Dollars) into my HSA Trust Account at the Bank specified below. Once elected, this before-tax payment will continue indefinitely until I change my election amount, in writing, as allowed under my company's Flexible Benefit Plan.
- Waive** I do not elect to contribute through salary reduction into my HSA Trust Account at this time.

- Catch-Up Election** wage and contribute an additional catch-up amount of \$ _____ per month into my HSA Trust Account.

Direct Deposit Authorization Agreement

I hereby authorized Benefit Plan Administrators to initiate credit entries and, if necessary, debit entries and adjustments for any credit entries made in error to my HSA Trust Account at the financial institution listed below.

Name of Financial Institution: _____

Financial Institution Routing/Transit Number: _____

Account Number: _____

Account Type: Checking Savings

This Employee Direct Deposit Authorization Agreement will remain in effect until written request is submitted to change or terminate this agreement.

HSA Trust Account Contribution Election Form (Continued)

Purpose: This agreement is designed to allow an employee to convert a portion of his/her taxable earnings to a tax-free benefit, pursuant to a 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 _____.
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 ends 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 of the statements above 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 that 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. : 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.

I understand dollars contributed through salary reduction into my HSA Trust Account are not subject to federal, state, Social Security and/or Medicare contributions and that future Social Security benefits may be affected by participation in this Plan. I also understand that dollars contributed to the HSA Trust Account through salary reduction cannot be used as a deduction on my tax return.

Employee Signature _____ Date _____

Employer Signature _____ Date _____