Health Savings Account (HSA) Contribution Election Form

Employer Information

Parish/School/Institution ______ City ______ Location No. ______

Employee Information

Last Name ______ First Name ______ Social Security No. ______

Personal Phone No. ______ Work Phone No. ______ Personal Email ______

Street Address ______ City ______ State ______ Zip ______

HDHP Insurance Coverage Selected: ☐ Employee ☐ Family

HSA Contribution Election Amount

The HSA 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 Account each year. The additional catch-up value is $1,000.

☐ Accept $ ______ per month

I elect to reduce my gross wages and contribute as stated above (include Benefit Dollars) into my HSA Account at the Bank specified below. This pre-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 Account at this time.

☐ Catch-Up Election $ ______ per month

I elect to reduce my gross wages and contribute an additional catch-up amount as stated above into my HSA Account at the Bank specified below.

Employer Benefit Dollar Contribution is: $ ______

Direct Deposit Agreement

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

Financial Institution: ______

Address: ______

City, State & Zip: ______

Bank Routing Number: ______
(First nine digits located on personal checks)

Account Number: ______ ______
Type of Account (checking or savings)

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

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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 on signing date.

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 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 Account. If I no longer qualify to participate in the HSA Plan, then I must stop my contributions into the HSA Account immediately. Dollars contributed to the HSA 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 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 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 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 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 Account. If I no longer qualify to participate in the HSA Plan, then I must stop my contributions into the HSA Account immediately. Dollars contributed to the HSA 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 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 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 Account through salary reduction cannot be used as a deduction on my tax return.

____ ____________________

Employee Signature **Date**

____ ____________________

Employer Signature **Date**