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## ELECTION CHANGE FORM FOR THE HEALTH SAVINGS ACCOUNT (HSA) WITH HSA BANK

Employer \_\_\_\_\_ Employee Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ E-mail (required) \_\_\_\_\_

### OPTION **1** HEALTH SAVING ACCOUNT ELECTION CHANGE FORM – Annual/Per Pay Change

**This option is available only to those Employees who have established a Health Savings Account and have completed applicable Applications and paperwork for proper establishment of a qualified HSA.**

YES I elect to **CHANGE my PLAN YEAR ELECTION** from \$ \_\_\_\_\_ (current election) to \$ \_\_\_\_\_ for the **REST OF THE PLAN YEAR**. (Please calculate based on the number of pays LEFT in your Plan Year. See HR/Payroll for this information.)

**This will CHANGE my PER PAY ELECTION/CONTRIBUTION** from \$ \_\_\_\_\_ (current election) to \$ \_\_\_\_\_ per pay period.  
(THIS IS THE PER PAY ELECTION AMOUNT.)

**\*\*\*\*MUST COMPLETE: DATE OF PAYROLL CHANGE:** \_\_\_\_\_

(NOTE: Make sure your change is not exceeding the statutory IRS Maximum for contribution to an HSA. Ask BMS for these details.)

### OPTION **2** HEALTH SAVING ACCOUNT ELECTION CHANGE FORM – One Time Change

YES I elect to **make a ONE TIME CONTRIBUTION** of \$ \_\_\_\_\_ to be added to my current Plan Year Election.

**\*\*\*\*MUST COMPLETE: DATE OF PAYROLL CHANGE:** \_\_\_\_\_

(NOTE: Make sure your change is not exceeding the statutory IRS Maximum for contribution to an HSA. Ask BMS for these details.)

**IF EMPLOYER IS CONTRIBUTING TO THE HSA: The Employer has elected to CHANGE ELECTION to \$ \_\_\_\_\_ for the PLAN YEAR which is \$ \_\_\_\_\_ per pay period.  
(Must be completed by the Employer if applicable to Plan Set-Up.)**

Reminder: The Health Savings Account allows for participants to pay for qualified healthcare expenses covered by the High Deductible Health Plan (HDHP) as described in IRS Code Section 223. 1.) I understand that I can only participate in this Plan if I am currently enrolled in my Employer's HDHP/HSA Health Plan. 2.) I understand that I am not entitled to Medicare Benefits. 3.) I understand that the HDHP Plan must meet minimum requirements and deposits cannot exceed the indexed maximums outlined by the IRS. I agree to follow all rules and regulations as outlined by the IRS with respect to HSA Account and I understand I must complete any applicable Custodial Bank Applications in order to establish my HSA Account with an IRS approved Custodian.

My employer and I agree that my taxable income will be reduced during the year by an equal portion of the benefit elections (1-2) set forth above and that qualified expenses will be paid on a tax-free basis, I understand that I may change my election only in the event of certain changes in my status and that, prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit election for the upcoming Plan Year. I have also read and understand the Important Information provided with enrollment materials.

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_

<b>TO BE COMPLETED BY EMPLOYER</b>	Plan year start (mm/dd/yy) _____/_____/_____ and end _____/_____/_____
	First payroll start date _____/_____/_____ Pay Cycle _____
	Custodial HSA Application Submitted with this Election Form _____ (new accts. only)
	<b>02/11 version</b>