BMS LLC
BENEFIT MARKETING SOLUTIONS

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ELECTION FORM FOR THE HEALTH SAVINGS ACCOUNT (HSA)

Employer_____ Employee Name_____

Social Security # _____ Date of Birth _____

Mailing Address _____City _____State_____ Zip_____

Home Phone (_____) _____ E-mail **(required)** _____

Please Confirm your High Deductible HSA Medical Plan Coverage Level

Single _____ Employee+Child(ren _____ Employee+Spouse_____ Family _____

OPTION 1 HEALTH SAVING ACCOUNT AGREEMENT

☐ YES I elect to contribute $_____ (before taxes) for the PLAN YEAR, which is $_____ per pay period (please calculate based on the number of pays in your Plan Year) to fund my account that pays for qualified healthcare expenses covered by my 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.*

OPTIONAL : **My Employer** has elected to contribute $_____for the PLAN YEAR which is $_____ per pay period.
(Must be completed by the Employer to be processed by BMS.)

☐ NO I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 2 AGREEMENTS TO SAVE TAXES ON INSURANCE PREMIUMS

☐ YES On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i. e. health insurance.) I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

☐ NO I decline this option for this plan year and understand that I will lose all tax savings that I could receive as participant.

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**_____

TO BE COMPLETED BY EMPLOYER

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)

7/16 version