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ELECTION CHANGE FORM
FOR THE HEALTH SAVINGS ACCOUNT (HSA)

Employer________________________________Employee Name____________________________________

Social Security #______________________________________Date of Birth__________________________

Mailing Address_________________________________City______________State_________Zip__________

Home Phone (_____)______________________E-mail Address____________________________________

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.)

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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.)

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Reminder: The Health Savings Account allows for participants to pays 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____________________

MUST BE COMPLETED BY EMPLOYER	Plan year start (mm/dd/yy) ____/_____/____ and end _____/_____/____ Effective Date of HSA Change _____/____/_____ Pay Cycle ___________

08/21 version