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ELECTION FORM FOR THE HEALTH SAVINGS ACCOUNT (HSA)

PLEASE PRINT CLEARLY AND LEGIBLY

Employer_____Employee Name_____

Social Security #_____Date of Birth_____

Mailing Address_____City_____State_____Zip_____

Home Phone(_____)_____E-mail Address_____

Gender _____Marital Status_____Mother's Maiden Name_____

Debit Card Information for Participants: I understand that an HSA Debit Card will be ordered for me based on the election(s) indicated below. **NOTE**: I agree to use the Debit Card for only qualified medical and/or qualified daycare expenses. I understand that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I also understand that if a payment is made that is not for qualified expenses under IRS guidelines, or if I fail to provide adequate documentation to substantiate an FSA Card swipe, I will repay the Plan. If I fail to reimburse the Plan, I authorize the Plan Sponsor to withhold such non-qualified expenses, including taxes, penalties, fines, or surcharges, from my payroll to the extent permitted by law. I also understand that I am responsible for submitting all requested receipts to BMS to validate my card usage as required under IRS guidelines. Usage of the Debit Card at a qualified merchant does not negate the need to submit receipts per current IRS rules and regulations if requested and necessary. I agree to review my account online periodically at www.bmsllc.net to obtain information on open transactions that require substantiation. I realize that if I fail to respond to request for receipts within 60 days of the posting of the transaction, my Debit Card will be suspended. Full compliance and submission of required receipts will be necessary in order to reactivate my Card. Notification of open transactions will be *emailed* to the email address provided above or saved at my employee website at www.bmsllc.net. Also, the debit card agreement that is sent to me with my card outlines the individual participant's responsibility for proper use. *A valid e-mail address is a highly recommended for card use in order to be notified of items in need of receipts. **EXTRA CARDS**: If you wish to order extra cards for your spouse and/ or dependents, please visit your employee website at www.bmsllc.net or contact BMS after the start of the Plan Year. Must be for a qualified dependent under IRS rules and regulations. A fee of $1.50 per additional card issued will be deducted from your FSA.* **IMPORTANT: Before using a card, a participant must follow the instructions on the Card sticker to activate the card. If the card is not activated, transactions will decline at the point of sale.**

Please Confirm your High Deducible HSA Medical Plan Coverage Level

Single _____ Employee + 1 _____ Family _____

OPTION 1 HEALTH SAVINGS 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 a 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_____

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

08/21 version