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ELECTION CHANGE FORM FOR THE HEALTH SAVINGS ACCOUNT (HSA)

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 _____

MUST BE COMPLETED BY EMPLOYER	Date of Hire (mm/dd/yy) ____/____/____ Effective Date of Participation (mm/dd/yy) ____/____/____
	First payroll date (mm/dd/yy) ____/____/____ Pay Cycle _____ Dept. _____

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