



P.O. Box 43653 Louisville, KY 40253-0653 (502) 244-1161 (800) 919-BMSI FAX (502) 244-1162 www.bmsllc.net

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. 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. Also, the debit card agreement that is sent to me with my card outlines the individual participant's responsibility for proper use. 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 HSA. 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 Deductible 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
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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