



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

HEALTH SAVINGS ACCOUNT (HSA) – ELECTION CHANGE FORM

PLEASE TYPE OR PRINT CLEARLY AND LEGIBLY

Employer _____ Employee Name _____

Social Security # _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Phone Number (____) _____ E-mail Address (REQUIRED) _____

Please Confirm your High-Deductible HSA Medical Plan Coverage Level

Single

Family

OPTION 1 HEALTH SAVINGS ACCOUNT ELECTION CHANGE – Annual OR Per Pay Change

I elect to **CHANGE my PLAN YEAR (ANNUAL) ELECTION** for the HSA from \$_____ (current) to \$_____ for the **REMAINDER OF THE PLAN YEAR**. Please calculate based on the number of pay dates LEFT in your Plan Year. See HR/Payroll for this information. 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.

This will **CHANGE my PER PAY ELECTION/CONTRIBUTION** from \$_____ (current) to \$_____ per pay period.

*****MUST COMPLETE: DATE OF PAYROLL CHANGE:** _____

OPTION 2 HEALTH SAVINGS ACCOUNT ELECTION CHANGE – One Time Change

I elect to **make a ONE TIME CONTRIBUTION** of \$_____ to the HSA. This is to be **added** to my current Plan Year Election. 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.

*****MUST COMPLETE: PAYROLL DATE OF ONE TIME CONTRIBUTION:** _____

These options are available only to those Employees who have established a BMS Health Savings Account and have completed applicable Application(s) for proper establishment of an HSA.

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. 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 have also read and understand the Important Information provided with enrollment materials.

Employee Signature: _____ Date: _____

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