Health Savings Account Contribution Election and Eligibility Certification Form

Last Name	First Name	M.I.	Employee ID #	Birthdate
				/ /

Address	City	State	Zip

SSN	E-mail Address

Health Savings Account Contribution Election	
I wish to contribute the amount I have indicated to my Health Savings Account each pay period on a pre-tax basis. I understand this amount will be deducted from my pay until I indicate otherwise. (Employee and Employer contributions count towards the annual HSA contribution limits)	**$** _____ Per Pay Period
I wish to make a single contribution in the amount I have indicated to my Health Savings Account on a pre-tax basis. I understand this amount will be deducted from my pay one time only.	**$** _____

Health Savings Account Eligibility Certification

I understand that in order to contribute to a Health Savings Account (HSA), or have my Employer contribute to an HSA on my behalf, I must answer "TRUE" to all of the following questions.

	TRUE	FALSE
I ***am covered*** under a qualified high-deductible health plan (HDHP) as defined by IRS Code §223(c)(2).		
I ***am not covered*** by another **non**-**HDHP**, through a spouse or registered domestic partner. (exclude "permitted coverage" such as accident only, disability, dental, vision, long-term care and specific disease policies)		
I ***am not*** a dependent on another person's tax return.		
I ***am not*** enrolled in Medicare. (age 65)		
I ***am not covered*** under a general purpose medical flexible spending account (FSA) or Health Reimbursement Arrangement (HRA), either through my Employer or through a spouse or registered domestic partner. (exclude limited scope medical FSA and HRA accounts - vision and dental only)		

By signing this form, I certify that all of the statements above are true, and I will notify my Employer immediately in writing if I cease to meet any of these conditions. I also understand that my Employer will make contributions to an HSA on my behalf on the basis of my certification and that the Employer's HSA contributions and my own HSA contributions (if any) are subject to certain aggregate limits under federal tax law. I agree that it is my responsibility to ensure that total HSA contributions do not exceed these annual aggregate limits.

Signature: _____ Date: _____

For answers to questions, contact the Region I Employee Benefit Department at **800-450-2990**