

HSA Enrollment Form

If enrolling in an HSA, you MUST complete this form in addition to the online Health Insurance Open Enrollment Application AND the ACA Verification form.

Enrollment Type (circle one): New Participant Continuing HSA

Employee Category (circle one): Administrator Professional Educator
 Secretary Instruct. Support
 Admin. Support ROTC

Employment Status (circle one): Active Early Retiree (Age 55-65)

Building Location: _____

Employee Information

First Name _____ M.I. _____ Last Name _____

Home Street Address _____ Apt/Ste # _____

City _____ State _____ Zip _____

Email Address: _____ Contact Phone: _____

Marital Status (circle one): Single Married(date) _____
 Divorced(date) _____

List Covered Spouse and/or Dependent(s):

People may not use money from their health savings accounts for their covered dependents, unless their federal income tax returns also list the dependents. If the adult dependent child can't be listed as a tax dependent, any HSA deductions for the dependent would be taxable and subject to an Internal Revenue Service penalty. (Please contact your tax advisor if you have questions.)

HSA Plan coverage (circle one): Single Family

| First Name | Last Name | Date of Birth | Social Security # | Relationship |
|------------|-----------|---------------|-------------------|--------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

The information provided on this form is subject to verification audits at any time during the plan year. Audits could include a request for: birth certificates and marriage certificates.

HSA Election Amount

Please fill in the following dollar amounts for your elected HSA contributions for the 2014-15 Plan Year.

\$ per Paycheck: _____

Amount of Paychecks: 26

\$ Total Election Amount for the Plan Year: _____

Bank Information

To ensure we deposit the funds into your bank on a timely basis, please provide the following information about the bank and account you have chosen for your HSA funds.

Bank Name: _____

Bank Routing Number: _____

Account Number: _____

Authorization

By submitting this Section 223-Health Savings Account (HSA) Enrollment form, I understand that in order to establish my Health Savings Account: I have self-only coverage or family coverage under the Employer Group Health Plan which I confirmed qualifies as a High Deductible Health Plan (HDHP) under Code 223(c)(2); I cannot be claimed as another person's tax dependent; and I am not entitled to Medicare benefits. I further certify that I am not covered by any other form of non-HDHP health plan, general purpose health care flexible spending account (health FSA) or general-purpose health reimbursement arrangement (HRA). I agree to notify my Employer in writing immediately if I cease to meet any of these conditions. I also understand that any amounts contributed to my HSA (either Employer, your own, or both) are subject to certain aggregate limits under Federal tax law. I understand that my monthly Social Security retirement benefits may be reduced slightly by contributing pre-tax dollars (if eligible to do so) to the HSA.

By submitting this form, I understand that I authorize the School District of Beloit to deduct my employee premium contribution on a pre-tax basis. I understand that this is my annual open enrollment period and without a special enrollment period and without a special enrollment event I will not be allowed to make any changes to the coverage(s) I have elected.

Employee Name (please print first and last name) _____

Employee Signature _____ Date _____

Mail Form to:
Cindy McKillips
Kolak Education Center
1633 Keeler Avenue
Beloit, WI 53511