

Employee Name _____			
Address _____		City _____	State _____
Email for administrator system _____		Phone Number _____	Zip _____
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Renewal Enrollment <input type="checkbox"/> Contribution Change			

HSA ACCOUNT

In order to be eligible to make or receive HSA contributions, you must meet the following requirements:

- You must be enrolled in an HSA-qualifying High Deductible Health Plan (i.e. the City of Salem HDHP)
- You cannot be covered by any other health plan (i.e. a spouse's non HDHP plan or traditional health flexible spending)
- You cannot be covered by Medicare, Medicaid, or military health benefits
- You cannot be claimed as a dependent on another individual's tax return

AGREEMENT FOR HEATH SAVINGS ACCOUNT & AUTHORIZATION

Benefit	Contribution Per Paycheck <u>24 paychecks in a full calendar year</u>	# paychecks <u>24 per year</u>	Contribution per Plan Year
<input type="checkbox"/> I have waived coverage on the City of Salem health plan and elect the HSA for my Opt-Out Incentive. My other insurance is an HDHP medical plan.	<u>\$112.50</u> (\$225 per month) Pro-rated based on FTE for part-time	x ____ =	\$ _____
<input type="checkbox"/> I am enrolled in the City of Salem HDHP, and I am eligible to receive City contributions to the HSA.	<input type="checkbox"/> Employee Only <u>\$66.67</u> (\$133.34 per month) Pro-rated based on FTE for part-time OR <input type="checkbox"/> Employee + Dependents <u>\$133.33</u> (\$266.67 per month) Pro-rated based on FTE for part-time	x ____ =	A. <input type="checkbox"/> Employee Only \$ _____ OR <input type="checkbox"/> Employee + Dependents \$ _____
<input type="checkbox"/> I am enrolled in an HDHP medical plan and I elect to have the following amount deducted pre-tax from my paycheck.	\$ _____ Per paycheck	x ____ =	B. \$ _____ Per year
The 2024 combined annual A.) Employer, and B.) Employee contribution, cannot exceed: <ul style="list-style-type: none"> • \$4,150, if enrolled in employee only HDHP coverage; or • \$8,300, if enrolled in employee plus dependents HDHP coverage. If you have attained age 55, you may contribute an additional \$1,000 per year.		A + B =	\$ _____ Per year

- I authorize the City of Salem to deduct pre-tax payroll contributions to fund my Health Savings Account as specified above.
- I understand that if my employment is terminated prior to the end of the Plan Year, the City of Salem will no longer absorb the administrative costs associated with the account, at which time the administrative fees will be deducted from my HSA.
- I hereby certify the above information to be correct and true to the best of my knowledge. I understand that the above deductions may correspondingly reduce my future Social Security benefits.
- My signature on this form certifies that I assume responsibility for determining that I am eligible for HSA contributions, for ensuring contributions to my HSA do not exceed the annual limits set forth by tax law, for ensuring my HSA is used only for qualified health care expenses, and I am responsible for any tax consequences due to excess contributions and/or ineligible distributions.
- Contribution changes can be completed at any time during the calendar year. Contributions are deducted evenly during the year, but a lump sum or specific number of paychecks to meet the annual maximum contribution can be selected. The maximum annual contribution can be met on a final paycheck of the year provided the employee will remain enrolled in an HDHP medical plan for the remainder of the calendar year.

Employee Signature: _____ **Date:** _____

Employer Use Only	
Employee hire date (New enrollment only): _____ Employee effective date of coverage: _____ Verified contribution amount: <input type="checkbox"/> Verify age 55+ (if applicable): <input type="checkbox"/> Enrollment Reason: HDHP <input type="checkbox"/> or Health Insurance Opt-out (HDHP other insurance) <input type="checkbox"/> Division/BU: _____ HSA Tracking List: <input type="checkbox"/> Oracle B050: <input type="checkbox"/> Oracle Entry date: _____ New enrollment only: BOA website: <input type="checkbox"/> BOA Bank Acct# in Pay Method & B050: <input type="checkbox"/> Notify Payroll <input type="checkbox"/> HR Representative : _____ Date: _____	Employee #: _____ Employee first contribution date: _____ # of pay-periods remaining for the year: _____ FTE: Full-time <input type="checkbox"/> or Part-time <input type="checkbox"/> FTE: _____ Employer Per Paycheck \$ _____ Per Month \$ _____ Employee Per Paycheck \$ _____ Per Month \$ _____