HEALTH SAVINGS ACCOUNT ELIGIBILTY VERIFICATION AND SALARY REDIRECTION AGREEMENT

Employee Name:			**Social Security #:**
Address:		**City:**	**State:** **M or F (circle)**
Zip:	**Phone Number:**	**Email:**	**DOB: ___ /___ /_____**

ELIGIBLITY REQUIREMENTS **ALL FIELDS ABOVE MUST BE COMPLETED** **Single or Family Coverage (circle one)**

I understand that in order for me or for my Employer to contribute to a Health Savings Account (HSA) on my behalf, I must meet all of the following HSA eligibility conditions. I also understand that I must provide sufficient identifying information about my HSA to facilitate the forwarding of contributions through the Employer's payroll system to my designated HSA trustee/custodian.

1. I have single or family coverage under the Employer's High-Deductible Major Medical Plan (the Health Plan), which I understand qualifies as a high-deductible health plan (HDHP) under Code §223(c)(2).
2. I cannot be claimed as another person's tax dependent.
3. I am not entitled to Medicare benefits.
4. If I have any health coverage other than my coverage under the Health Plan, that coverage is either (a) HDHP coverage (*see Paragraph A below)* or (b) permitted non-HDHP insurance or coverage (*see paragraph B below*).

A. Qualified HDHP Coverage is the Following:

- *Self-Only Coverage:* To qualify as HDHP coverage, it must have a deductible of at least $1,400 for 2021 (indexed for inflation) before any coverage is provided for eligible medical expenses (other than preventive care). In addition, the sum of the deductible and other annual out-of-pocket expenses that the insured is required to pay (such as co-pays and co-insurance, but not premiums) cannot exceed $7,000 for 2021 (indexed for inflation).
- *Family Coverage:* Family coverage is any coverage other than self-only coverage. Family HDHP coverage must have a deductible of at least $2,800 for 2021 (indexed for inflation) before any coverage is provided for eligible medical expenses (other than preventive care). No amounts can be paid (other than for preventive care) until the minimum required family deductible has been satisfied (i.e., there cannot be an individual deductible within the family deductible that is less than the required minimum of $2,800 for 2021 (indexed for inflation). In addition, the sum of the deductible and other annual out-of-pocket expenses that the insured is required to pay (such as co-payments and co-insurance) cannot exceed $14,000 for 2021 (indexed).

B. Permitted Non-HDHP Insurance or Coverage Is the Following:

- Insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., homeowner or auto insurance), or similar liabilities as specified by the IRS;
- Insurance for a specified disease or illness (e.g., cancer insurance);
- Insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance); or
- Coverage for accidents, disability, dental care, vision care, or long-term care.

Examples of impermissible coverage that would make me ineligible include coverage under my spouse's or domestic partner's non-HDHP health plan, general-purpose health flexible spending arrangement (health FSA), or general-purpose health reimbursement arrangement (HRA).

ELECTION TO CONTRIBUTE TO HSA THROUGH PRETAX PAYROLL DEDUCTION (In addition to contributions made by the employer, if any)

Please deduct $_____ per pay and deposit to my HSA on my behalf. The annual maximum contribution (including employer contributions, if any) for 2021 is $3,600 for single HDHP coverage and $7,200 for family HDHP coverage. An additional $1,000 may be contributed if you are 55 or older. This election can be changed at any time, for any reason, effective no later than the first day of the calendar month after the change request is filed.

By signing this form and returning it to the Employer, I certify that all of the statements above are true. I agree that I will notify the Employer immediately in writing if I cease to meet any of these conditions. I also understand that the Employer may 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 my Compensation will be reduced by the amount of my required contribution for the Benefits that I have elected under the Plan and that such Salary Reductions will continue for each pay period until this Agreement is amended or terminated. I also understand the following:

- Signing this Agreement does not initiate my coverage under any Medical or Dental Insurance policies. I must complete separate Medical and/or Dental Insurance enrollment forms to start my coverages.
- Salary Reductions under this Agreement reduce my Compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.

I have read and agree to the terms of participation and to any applicable eligibility requirements as set forth in this Agreement. Any previous election and agreement under the Plan relating to the same Benefits, including any prior Salary Reduction Agreement, is hereby revoked.

Employee's Signature: _____ **Date:** _____

Approved By: _____ **Date:** _____
(company representative)

PLEASE RETURN THIS FORM TO _____ ***BY*** _____
(employer contact person) (date)