



HSA SALARY REDUCTION AGREEMENT

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Savings Account. **Do Not Send Contributions With This Form.**

HEALTH SAVINGS ACCOUNT ELIGIBILITY INFORMATION: In order to establish a Health Savings Account, you must be classified as an "Eligible Individual" under IRC Section 223, applicable sub-sections and rulings, collectively called the "Code". You are eligible for an HSA **ONLY** if you can meet the following requirements: (1) you are covered by a high deductible health plan ("HDHP"); (2) you are not covered by another health plan that is not a HDHP such as a FSA medical reimbursement account either through your company or that of your spouse; (3) you are not able to be claimed as a dependent by another taxpayer (excluding spousal dependents); (4) you are not entitled to benefits under Medicare.

By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" as defined above and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

Instructions

- Step 1** Complete the **PERSONAL INFORMATION** section. All information is required.
- Step 2** Complete the **HSA CONTRIBUTION ELECTION** section with your per payroll contribution amount.
- Step 3** Sign in the **SIGNATURES** section and return to your employer's designated person for processing.

PERSONAL INFORMATION

NAME: (please print) _____
(First) (M.I.) (Last)

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____

PHONE: _____ E-MAIL: _____

EMPLOYER NAME: _____

HSA CONTRIBUTION ELECTION

I ELECT A PAYROLL CONTRIBUTION OF \$ _____ TO MY HSA EFFECTIVE _____.
Amount Per Pay Period Date

The amount contributed to all HSA's for each calendar year may not exceed the maximum contribution limit plus any Catch-Up contributions allowed. This includes HSA accounts held at other financial institutions. For 2016, those limits are \$3,350 for individual coverage and \$6,750 for family coverage. For 2017, those limits are \$3,400 for individual coverage and \$6,750 for family coverage. For either year there is a \$1,000 Catch-Up contribution for individuals age 55 and older.

SIGNATURES

Employee Signature: As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that Benefit Solutions, Inc., your plan service provider, is facilitating but not initiating the contribution.

Employee Signature: _____ Date: _____

Employer Signature: The employee's election of the Health Savings Account Contribution is accepted as of the date shown below.

Authorized Signature: _____ Date: _____