P.O. Box 43653 Louisville, KY 40253-0653 **(502) 244-1161 (800) 919-BMSI FAX (502) 244-1162** ***www.bmsllc.net***

ELECTION CHANGE FORM FOR THE HEALTH SAVINGS ACCOUNT (HSA) WITH HSA BANK

Employer_________________________________ Employee Name_________________________________

Social Security # ____________________________ Date of Birth ______________________________

Home Address ________________________________City ________________State_________ Zip_________

Home Phone (_____) __________________________ E-mail **(required)** ____________________________

OPTION 1 HEALTH SAVING ACCOUNT ELECTION CHANGE FORM – Annual/Per Pay Change

This option is available only to those Employees who have established a Health Savings Account and have completed applicable Applications and paperwork for proper establishment of a qualified HSA.

☐ YES I elect to **CHANGE my PLAN YEAR ELECTION** from $___________ (current election) to $___________ for the **REST OF THE PLAN YEAR**. (Please calculate based on the number of pays LEFT in your Plan Year. See HR/Payroll for this information.)

This will CHANGE my PER PAY ELECTION/CONTRIBUTION from $__________ (current election) to $___________ per pay period.
(THIS IS THE PER PAY ELECTION AMOUNT.)

*****MUST COMPLETE: DATE OF PAYROLL CHANGE:*** ____________________________
(NOTE: Make sure your change is not exceeding the statutory IRS Maximum for contribution to an HSA. Ask BMS for these details.)

OPTION 2 HEALTH SAVING ACCOUNT ELECTION CHANGE FORM – One Time Change

☐ YES I elect to **make a ONE TIME CONTRIBUTION** of $___________ to be added to my current Plan Year Election.

*****MUST COMPLETE: DATE OF PAYROLL CHANGE:*** ____________________________
(NOTE: Make sure your change is not exceeding the statutory IRS Maximum for contribution to an HSA. Ask BMS for these details.)

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IF EMPLOYER IS CONTRIBUTING TO THE HSA: **The Employer** has elected to **CHANGE ELECTION to** $____________for the PLAN YEAR which is $________ per pay period.
(Must be completed by the Employer if applicable to Plan Set-Up.)

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Reminder: The Health Savings Account allows for participants to pays for qualified healthcare expenses covered by the High Deductible Health Plan (HDHP) as described in IRS Code Section 223. 1.) I understand that I can only participate in this Plan if I am currently enrolled in my Employer's HDHP/HSA Health Plan. 2.) I understand that I am not entitled to Medicare Benefits. 3.) I understand that the HDHP Plan must meet minimum requirements and deposits cannot exceed the indexed maximums outlined by the IRS. *I agree to follow all rules and regulations as outlined by the IRS with respect to HSA Account and I understand I must complete any applicable Custodial Bank Applications in order to establish my HSA Account with an IRS approved Custodian.*

My employer and I agree that my taxable income will be reduced during the year by an equal portion of the benefit elections (1-2) set forth above and that qualified expenses will be paid on a tax-free basis, I understand that I may change my election only in the event of certain changes in my status and that, prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit election for the upcoming Plan Year. I have also read and understand the Important Information provided with enrollment materials.

Employee Signature: ____**Date**________________________

TO BE COMPLETED BY EMPLOYER

Plan year start (mm/dd/yy) _____/_____/_____ and end _____/_____/_____
First payroll start date _____/____/_____ Pay Cycle ________________
Custodial HSA Application Submitted with this Election Form___________(new accts. only)

02/11 version