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ELECTION FORM FOR THE HEALTH SAVINGS ACCOUNT (HSA)

Employer _____ Employee Name _____

Social Security # _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ E-mail (required) _____

OPTION 1 HEALTH SAVING ACCOUNT AGREEMENT

YES I elect to contribute \$ _____ (before taxes) for the PLAN YEAR, which is \$ _____ per pay period (please calculate based on the number of pays in your Plan Year) to fund my account that pays for qualified healthcare expenses covered by my 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.

OPTIONAL : My Employer has elected to contribute \$ _____ for the PLAN YEAR which is \$ _____ per pay period. (Must be completed by the Employer to be processed by BMS.)

NO I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 2 AGREEMENTS TO SAVE TAXES ON INSURANCE PREMIUMS

YES On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i. e. health insurance.) I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

NO I decline this option for this plan year and understand that I will lose all tax savings that I could receive as participant.

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)
10/10 version	