



ELECTION FORM FOR YOUR EMPLOYER HEALTH SAVINGS ACCOUNT PLAN

Employer _____ Employee Name _____
 Social Security # _____ Date of Birth _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ E-mail (required) _____

THIS AGREEMENT IS TO ALLOW MY EMPLOYER TO WITHHOLD HSA DEDUCTIONS FROM MY PAYCHECK ON A PRE-TAXED BASIS. THE OPTION WILL BE OFFERED THROUGH MY GROUP SECTION 125 CAFETERIA PLAN. SINCE THE DEDUCTIONS WILL BE THROUGH A GROUP SECTION 125 PLAN ADMINISTERED BY BMS LLC, I CANNOT ADJUST THE CONTRIBUTIONS DURING THE PLAN YEAR WITHOUT MEETING CERTAIN ELIGIBILITY REQUIREMENTS. (Note- You can make personal deposits into your HSA bank account but this amount will not be reflected with your group sponsored payroll deductions for the plan year and you will be required to stay below the IRS annual index limit for contributions each year.)

YES On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i. e. HSA qualified High Deductible Health Plan) and I understand that my share of the premiums and/or HSA contributions 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.

HSA ANNUAL AMOUNT TO BE WITHHELD \$ _____

PAYROLL DEDUCTION PER PAY \$ _____

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 set forth above and that qualified expenses will be paid on a tax-free basis, I understand that I may change my election 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 acknowledge that I have received, read and understand the Summary Plan Description and/or the requirements for the HSA enrollment under the IRS guidelines set forth in this calendar year. I have also read and understand all the information provided with enrollment materials.

Employee Signature: _____ Date _____

TO BE COMPLETED BY EMPLOYER	
Employee # _____	Plan year start (mm/dd/yy) ____/____/____ and end ____/____/____
Dept. _____	First payroll start date ____/____/____ Pay Cycle _____