FARIBAULT PUBLIC SCHOOLS – ISD #656

HEALTH SAVINGS ACCOUNT (HSA) EMPLOYEE CONTRIBUTION ELECTION FORM

(To be completed and returned to your employer)

ACCOUNT OWNER

_____ _____
Employee's Last Name First Name M.I. SMARTeR ID#

_____
Street Address City State Zip Code

_____-_____-_____ (____)_____ (____)_____
Social Security No. Daytime Phone Evening Phone or Email address

CONTRIBUTIONS

☐ YES, I accept the district contribution to my HSA account each period with my enrollment in the qualifying health insurance plan as allowed by contract language. I am aware that I may modify this decision during the annual enrollment period.

OR

☐ NO, I do not accept the available district HSA contribution available with my enrollment in the qualifying health insurance plan as allowed by contract language. I am aware that I may modify this decision during the annual enrollment period.

AND *(check and complete one statement below. Zero (0) is an accepted amount).*

☐ I wish to contribute $_____to my HSA account each pay period on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise. Requested Start Date _____

☐ I wish to make a single contribution of $_____to my HSA account on a pre-tax basis. I understand this will be deducted from my paycheck one time only for the current tax year. Contribution Date _____

SIGNATURE

It is my responsibility (1) to determine whether I am eligible to make contributions to my HSA, and (2) to determine whether contributions to this HSA have exceeded the applicable maximum annual contribution limit.

_____
Account Owner Signature Date

RETURN FORM TO YOUR EMPLOYER BY JUNE 15 TO AFFECT SUMMER PAYOFF CHECKS.

OFFICE USE ONLY. Contribution request approved.

_____
Employer Representative Signature *Date*

Payroll/Benefits Department Use Only *HSA_____R: $ _____*
HSA_____FLX: $ _____ Entered by:_____ Date:_____