HSA ENROLLMENT INFORMATION

APPLICANT INFORMATION

EMPLOYER	HIRE DATE	PLAN EFFECTIVE DATE	☐ NEW ENROLLMENT ☐ CHANGE	☐ 2013 Plan Year ☐ 2014 Plan Year

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

PHONE NUMBER	EMAIL ADDRESS

GENDER ☐ Female ☐ Male	MOTHER'S MAIDEN NAME	MARITAL STATUS ☐ Unmarried ☐ Married	COVERAGE LEVEL ☐ Single ☐ Family

PREFERRED REIMBURSEMENT METHOD ☐ Check ☐ Direct Deposit	PAYROLL FREQUENCY ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

BANK NAME (IF DIRECT DEPOSIT IS SELECTED)	ACCOUNT NUMBER	ROUTING/TRANSIT NUMBER

CITY	STATE	ACCOUNT TYPE ☐ Checking ☐ Savings

DEBIT CARD ☐ Yes ☐ No	SPOUSE DEBIT CARD ☐ Yes ☐ No	SPOUSE NAME	SPOUSE DATE OF BIRTH

HEALTH SAVINGS ACCOUNT ELECTION

MY PAYROLL CONTRIBUTION IS TO BE IN THE AMOUNT OF:

$ _____
PER PAYROLL DEDUCTION

2014	Individual Coverage	Family Coverage
Annual Maximum	$3,300	$6,550
Catch-up Contribution (55 or older)	$1,000	$1,000

FOR A SPECIAL PAYROLL DEDUCTION ARRANGEMENT, PLEASE EXPLAIN:

Note: This election remains in effect until the end of the plan year unless changed. Changes may be made online or by submitting a new HSA Enrollment Information form. A new election must be made at annual enrollment for the next plan year.

ACKNOWLEDGEMENT AND SIGNATURE

This enrollment form is to open or change an existing Health Savings Account that is used to accumulate assets for the payment of qualified healthcare expenses. Your Health Savings Account is your financial asset even if you change employers or health plans. To open a Health Savings Account you must meet three criteria: 1) You must be covered by a qualified high deductible health plan, 2) You cannot be covered by another health plan, including Medicare and 3) You cannot be claimed as a dependent on another individual's tax return.

By signing my name below, I understand and acknowledge that:

I have read and understand the accompanying HSA Custodial Agreement and Disclosure Statement and agree to be bound by those terms and conditions. I understand the eligibility requirements for this HSA and I state that I am responsible for determining whether I qualify to make deposits to this HSA. I am responsible for:

a. determining that I am eligible to make contributions to an HSA for each year I make a contribution;
b. ensuring that all contributions are within the maximum limitations set forth by the tax laws, taking into account my coverage under a high deductible health plan;
c. the tax consequences of any contributions (including rollover contributions) or distributions; and
d. seeking the assistance of a qualified tax or legal professional to address any questions or concerns I may have about eligibility, contribution limitations, or the taxation of contributions or distributions from my HSA.

_____ _____

EMPLOYEE SIGNATURE **DATE**

PLEASE SEND COMPLETED FORM TO:

MAIL: **Conservation Employees' Benefits Plan**
P.O. Box 507
Jefferson City, MO 65102-0507

E-MAIL: **HRBenefits@mdc.mo.gov**

FAX: **1-573-751-9099**