# HEALTH SAVINGS ACCOUNT EMPLOYEE CONTRIBUTION ELECTION FORM

**Maximum Contribution: Single = $3,650.00 Family = $7,300.00**

(To be completed and returned to your employer)

**Employer Name:** Hartford School District

## ACCOUNT OWNER'S NAME AND ADDRESS

_____

**Last Name** **First Name** **Middle Initial**

_____

**Street Address**

_____**City**

**State** **Zip Code**

_____

**Social Security No.** **Date of Birth** **Daytime Phone** **Evening Phone**

## CONTRIBUTIONS

☐ 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.

☐ 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 tax year _____.

## 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 Date

# Employee Certification of HSA Eligibility

Employee Name: Birth Date:

I understand to be eligible for [Employer Name] to contribute to a health savings account (HSA) on my behalf, I must meet *all** of the following HSA eligibility conditions:

1. I have ☐ self-only coverage *OR* ☐ two-person/parent/child(ren) or family coverage under the VEHI Gold CDHP or Silver CDHP (the Health Plan), which I understand qualifies as an HSA compatible health plan under Internal Revenue Code §223(c)(2).
2. I cannot be claimed as another person's tax dependent.
3. I am not entitled to Medicare benefits.
4. I am not eligible for Tricare benefits.
5. I am ☐ not entitled to benefits under the V.A. *OR* ☐ I am entitled to benefits under the V.A. and I have a V.A. disability rating**.**
6. If I have any health coverage in addition to my coverage under the Health Plan, that coverage is either:
    a. HSA compatible CDHP coverage (*see paragraph A on the reverse side of this form*); or
    b. permitted *non*-CDHP insurance or coverage (*see paragraph B on the reverse side of this form*).

Examples of impermissible coverage that would make me ineligible include coverage under:

- my spouse's or domestic partner's *non*-CDHP health plan,
- any general-purpose medical flexible spending arrangement (medical FSA), including my spouse's medical FSA (limited purpose FSA is permitted) , or
- a general-purpose health reimbursement arrangement (HRA).

By signing this form and returning it to the Employer, I certify that all the statements above are true. I agree that I will notify the Employer immediately in writing if I cease to meet any of these conditions. I also understand that the Employer will make contributions to an HSA on my behalf on the basis of my certification and that the Employer's HSA contributions and my own HSA contributions (if any) are subject to certain aggregate limits under federal tax law.
If there is any change to my HSA eligibility, I must notify my employer of the change as soon as possible and not later than 30 days after the event.

_____ _____, 20___
Employee Signature Date

*Note: If the employer agrees, through the collective bargaining process where applicable, to contribute to an HSA of an employee not enrolled in the employer HSA-qualified health plan but enrolled in another CDHP HSA-qualified health plan, language should be added to include this option on the certification form. In addition, the employer should require certification as well as documentation that the other coverage is an HSA-qualified plan, and require the employee provide the employer prompt notice if this other coverage terminates and/or is no longer an HSA-qualified plan, therefore making the employee ineligible for HSA contribution.

**A. CDHP Coverage Is Health Coverage That Meets the Following Requirements:**

- ***Self-Only Coverage:*** Self-only coverage is coverage of one individual. To qualify as CDHP coverage, it must have a deductible of at least $1,400 for 2020 before any reimbursement is made for eligible medical expenses (other than preventive care). In addition, the sum of the deductible and other annual out-of-pocket expenses that the covered employee is required to pay (such as copays and coinsurance, but not premiums) cannot exceed $6,900 for 2020.

- ***Family Coverage:*** Family coverage is any coverage other than self-only coverage. Family CDHP coverage must have a deductible of at least $2,800 for 2020 before any reimbursement is made for eligible medical expenses (other than preventive care). No amounts can be paid (other than for preventive care) until the minimum required family deductible has been satisfied (i.e., there cannot be an individual deductible within the family deductible that is less than the required minimum of $2,800 for 2020). In addition, the sum of the deductible and other annual out-of-pocket expenses that the covered individual is required to pay (such as copayments and coinsurance, but not premiums) cannot exceed $13,800 for 2020 (no single person can be required to pay more than $6,900).

**B. Permitted Non-CDHP Insurance or Coverage Includes the Following:**

- insurance under workers' compensation laws, tort liabilities, homeowner or auto insurance, or similar liability insurance;
- insurance for a specified disease or illness (e.g., cancer insurance policy);
- insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance); or
- coverage for accidents, disability, dental care, vision care, or long-term care.
- limited purpose flexible spending account (LPFSA)

**IMPORTANT NOTICE**

The information provided is general in nature and is not intended, nor should it be construed as, legal or tax advice. Since the administration of an HSA is a taxpayer (your) responsibility, you are also encouraged to review information available from the Internal Revenue Service (IRS) for taxpayers, which can be found on the IRS Web site at https://www.irs.gov/. You can find IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, https://www.irs.gov/pub/irs-pdf/p969.pdf and IRS Publication 502, Medical and Dental Expenses, https://www.irs.gov/pub/irs-pdf/p502.pdf online or you can call the IRS to request a copy of each at 800-829-3676.