



Health Savings Account (HSA) Enrollment Form

(ONLY FOR THOSE ENROLLING IN THE HEALTH SAVINGS PLAN)

(PLEASE PRINT FIRMLY – USE BALL POINT PEN)

Section 1: EMPLOYEE INFORMATION

1. NAME-LAST		FIRST	INITIAL	2. SOCIAL SECURITY NUMBER	
3. MAILING ADDRESS			CITY	STATE	ZIP CODE
4. PHYSICAL ADDRESS (IF DIFFERENT THAN ABOVE)			CITY	STATE	ZIP CODE
5. HOME PHONE NO. ()	WORK PHONE NO. ()	6. MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		7. EMAIL ADDRESS	

Section 2: HSA PAYROLL DEDUCTIONS

I HEREBY ELECT TO PARTICIPATE IN THE HEALTH SAVINGS ACCOUNT AND I AM ENROLLED IN THE UA HEALTH SAVINGS PLAN

EMPLOYEE HSA CONTRIBUTION AMOUNT PER PAY PERIOD

\$

Section 3: SUBSCRIBER ACKNOWLEDGEMENT

- I am choosing to participate in the Health Savings Account (HSA) Plan.
- I understand that my spouse (if applicable) and I cannot be enrolled in a Health Care Flexible Spending Account (FSA) through an employer Section 125 or Cafeteria Plan.
- I understand that the FSA allows me to carry over up to \$500 of unused amounts remaining in my Health Care FSA at the end of the current Plan Year, to be used for medical care expenses. I further understand that if I carry over unused FSA amounts to the next Plan Year, I will be ineligible to contribute to an HSA for the entire Plan Year to which the unused amounts are carried over.
- I and my covered family members (if applicable) do not have any type of additional medical insurance coverage other than the UA Health Savings Plan. I understand that this includes enrollment in or eligibility for Medicare.
- I understand the HSA election I have made will remain in place until I notify my employer of a change to my HSA election in writing by submitting a new HSA Enrollment Form.
- I understand It is my responsibility:
 - To determine whether I am eligible to make contributions to my HSA; and
 - To determine whether contributions to this HSA have exceed the applicable maximum annual contribution limit. I acknowledge that I may be liable for tax penalties if I exceed this amount.

Section 4: EMPLOYEE AUTHORIZATION

I authorize the University to open a Health Savings Account (HSA) for me with Optum Bank, Inc. Effective January 1, 2018, all employer and employee HSA contributions will only be made to Optum HSAs.

___ Yes, I wish to have an Optum HSA so I can continue to receive contributions from the University to my HSA as well as any amounts that I elect to save through pre-tax payroll deductions.

___ No, I do not want an Optum HSA, and I realize that I will not receive any employer contributions to my HSA and that I will not be able to save in my HSA through pre-tax payroll deductions.

Section 5: SIGNATURE

I hereby authorize deductions from my earnings of any required contributions. To the best of my knowledge and belief, all statements and answers to the questions on this application are complete and true, and I agree that the statements will be the basis of the insurance coverage. I agree to notify my Human Resources office concerning any changes in the above information.

Employee Signature

Date

FOR EMPLOYER/OFFICE USE

CAMPUS: ASMSA CES UAF Criminal Justice UA Foundation UA Walton Center

EFFECTIVE DATE _____

UACCB UALR UAM UAMS UAPB WRI PCCUA UA FS UAPulaski Tech

DATE OF CHANGE _____

Other _____

REASON FOR CHANGE _____