OSSEO AREA SCHOOLS - ISD 279
HSA ENROLLMENT FORM

PLAN YEAR: July 01 - June 30 **EFFECTIVE DATE:** _____

EMPLOYEE INFORMATION:

Name: _____ Employee #: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth:_____ Gender: ☐ Male ☐ Female

Social Security #: _____

Primary Phone: _____ Work Phone: _____

Date of Hire:_____ Hours worked per week:_____

Email Address: _____ Contract Group: _____

Health Savings Account*

Employer Election (check one)

☐ $100 contributed per pay period for those electing Single coverage

☐ $200 contributed per pay period for those electing Single+1 or Family coverage

Employee contribution per payroll (optional): $_____**

☐ Waive Coverage (I do not qualify for the HSA contribution)

*To be eligible you cannot also be enrolled in another health plan that would disqualify an HSA contribution.
**Cannot exceed the IRS maximum per calendar year of $3,400 for those electing single health insurance or $6,850 for those electing family health insurance.
***I understand that I am required to supply PlanSource with my email address for purposes of establishing an HSA account.

Please check the box and initial if you have received and read the HSA Custodial Agreement and Disclosure Statement (available on district web site)

☐ **Yes** **Initials**_____

I understand that I may be required to provide documentation to substantiate the claim for an expense paid with the debit card and that I must do so within the timeframe stated in the request. In the event that I do not provide the required documentation and fail to repay the unauthorized charge; my employer will deactivate the card and consider the charge a debt to the organization and may deduct the charge from my paycheck.
*I understand that I am required to supply PlanSource with my email address for purposes of establishing an HSA account.

ENROLLMENT AUTHORIZATION:

I understand the benefit options and requirements presented therein. I am enrolling for the eligible benefits I indicate in the COVERAGE section and I authorize reductions from my earnings. I understand and agree that if my eligible expenses do not reach the amount I have allocated to that benefit, I will forfeit any amounts remaining in my participant account at the end of the Plan Year. I assume this risk of forfeiture of moneys remaining in my flex accounts. I also understand that all expenses for which I seek reimbursement must be for services performed during the Plan Year and while I am a participant in the Flexible Benefits Plan. I understand payments for Reimbursement Accounts will be made directly to me. I understand that I cannot revise or revoke this Enrollment Authorization or in any way change the amounts deducted from my salary during the Plan Year, except where the change is consistent with a family status as defined in the Flexible Benefits Plan. I agree to observe the terms and conditions of the Flexible Benefits Plan and all rules and regulations established by the Company to administer the Plan. I understand that the Employer cannot be held responsible for the tax consequences which may or may not result from the benefit(s) I have selected above. This plan is regulated by Internal Revenue Code Sections 105, 125, and 129, and is subject to discrimination regulations. In the event that the plan is found to be out of compliance with discrimination rules, I may be required to reduce or eliminate my pre-tax deduction election. I understand that I may be required to provide documentation to substantiate the claim for an expense paid with the debit card and that I must do so within the timeframe stated in the request. In the event that I do not provide the required documentation and fail to repay the unauthorized charge; my employer will deactivate the card and consider the charge a debt to the organization and may deduct the charge from my paycheck.

PlanSource
701 Xenia Ave S, #150
Minneapolis, MN 55416
Phone: (612) 256-0849 Fax: (407) 386-8937

_____ _____

EMPLOYEE SIGNATURE **DATE**