New Hire

Health Savings Account (HSA) Enrollment Form

Must enrolled in the HSA if enrolling in the HDHP, even if you are electing a zero employee contribution.
Must be enrolled in the High Deductible Health Plan (HDHP) through State Group Health to enroll in the HSA

Form Instructions: Please complete all entries on this form. Please print, sign and date this form, and submit to your Employer Benefits Specialist or Payroll Benefits Staff.

STEP 1: HSA Enrollee Personal Information

Section 326 of the USA PATRIOT Act requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account.

First Name:	Last Name:		
Employer Name:	Employee ID:		
Permanent Address:	City:	State:	Zip Code:
Day Time Phone Number:	Email Address:		
Social Security Number: __ __ __ / __ __ / __ __ __ __	Date of Birth: (Month/Day/Year) __ __ / __ __ / __ __ __ __		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Enrollment Status: ☐ New enrollment ☐ Re-enrollment		
Health Plan Coverage: ☐ Single ☐ Family			

STEP 2: HSA Qualifications

Your HSA is your financial asset even if you change employers or health plans. You must meet the requirements under Internal Revenue Code Section 223 to be eligible to contribute to an HSA. This means that:

1. You must be covered by a qualified high deductible plan.
2. You cannot be covered by another health plan, including Medicare or Flexible Spending Account. (You may be covered by a Limited Use Flexible Spending Account or Limited Use Health Reimbursement Arrangement.)
3. You cannot be claimed as a dependent on another individual's tax return.

Consult IRS Publication 969 for more information about HSA eligibility requirements.

STEP 3: HSA Elections

☐ Select HSA ☐ Decline HSA	Annual Employer Contribution:	
I. Annual Employee Contribution (Not to Exceed Contribution Maximums*)	II. Number of regular pay periods:	III. Contribution per pay period (I divided by II)

STEP 4: Account Holder Authorization

The HSA Enrollee named above hereby certifies that the information set forth in this HSA Enrollment Form is correct, and that the HSA Enrollee is applying to open a Health Savings Account at ConnectYourCare, LLC ("CYC"). Once the HSA is opened, CYC will serve as the custodian of your HSA, which consists of all the funds in your HSA deposit account, as well as any other investments you make through CYC with your HSA funds. HSA Enrollee acknowledges receipt of the CYC Custodial Agreement and agrees to be bound by the terms and conditions as set forth in the Custodial Agreement. HSA Enrollee will be sent a debit card that will access this HSA, once the HSA has been opened by CYC. The debit card will be governed by the Cardholder Agreement that will be sent with the card.

The HSA Enrollee understands that they must return this Enrollment Form to their employer, or the employer's designated benefit administrator, and authorizes and directs CYC to provide any information about your HSA, including your account number, account balance, or any other non-public personal information to your employer, or your employer's designated benefit administrator, in connection with the establishment and maintenance of your HSA.

HSA Enrollee acknowledges that he or she has not relied on CYC for personal tax or insurance advice and that CYC is not responsible for determining whether HSA enrollee is qualified to open or contribute to an HSA in accordance with Section 223(c) of the Internal Revenue Code.

Account Holder Signature:	Date:

*The total combined amount of both employer and employee contributions cannot exceed IRS maximum contribution limits. For 2020, that limit is $7,100 for employees with family HDHP coverage, $3,550 for self-only coverage, and $1,000 additional catch-up contribution allowed for employees age 55 or older. IRS regulations are indexed annually for inflation. If you want to contribute the total annual amount for a tax year in which you were only HSA eligible for a portion of that year, you must remain HSA eligible through the end of the next tax year or face tax penalties.

Return to HR: Attach to an HR Help Desk Request or fax 608-263-5778

ENROLLMENT TERMS AND CONDITIONS

I elect to participate in the Health Savings Program and agree to be bound by the terms of the Plan.

I understand that:

- The Health Savings Account (HSA) program is a benefit established for eligible state employees enrolled in one of the It's Your Choice (IYC) High Deductible Health Plans (HDHP). The HSA program is authorized under Internal Revenue Service (IRS) Code Sections §125, §105, and §223 and Wisconsin Statutes §40.515.
- A new enrollment must be completed each plan year. If I do not complete enrollment during open enrollment, I forfeit the opportunity to participate in the HSA benefit option.
- The annual HSA contribution amount I elect will be deducted from my paycheck a on pre-tax basis. If I do not wish to have my HSA contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my human resource or benefit office.
- Pre-tax HSA contribution deductions reduce my compensation for Social Security benefit purposes.
- According to Wisconsin Statutes §40.87, participation in an HSA will not reduce my wages for calculating state retirement benefits. Also, my contributions in an HSA will not reduce my gross income for the purpose of calculating any other state benefits such as sick leave conversion credits, income continuation insurance, life insurance, deferred compensation, unemployment, or worker's compensation.
- Contributions made into one account cannot be transferred and used for expenses in any other account.
- Contributing to an HSA is completely voluntary, and payments from my HSA are independently reviewed for compliance with IRS regulations.
- Generally, contributions to an HSA are made on a month-to-month rule basis depending on what coverage I am enrolled in under the IYC HDHP on the first day of the month. For each month that I am enrolled in individual coverage a total of $295.83 per month can be contributed. For each month that I am enrolled in family coverage a total of $591.66 per month can be contributed. If I change enrollment in the IYC HDHP during the plan year, I can change my contributions based on the month-to-month rule. For example, I am enrolled in individual coverage for 6 months of the year and the other 6 months in family coverage. My total contributions are: (6 x $295.83) + (6 x $591.66) or $1,774.98 + $3,549.96 = $5,324.94.
- There is a limited exception to the month-to-month rule described above. This exception allows me to make the maximum annual contribution for the plan year based on my enrollment in the IYC HDHP and HSA on December 1st. Using the same 6-month example above, assume I change from individual to family coverage during the second half of the year. Under the month-to-month rule, I am limited to a maximum contribution of $5,324.94. Since I was enrolled in family coverage on December 1st, I can use the limited exception and can contribute the full family HSA contribution amount of $7,100.
- IMPORTANT NOTE: In order to use this limited exception, I have to stay enrolled in the IYC HDHP and HSA at the same or higher level of coverage for the entire next plan year, called the 'testing period'. If I do not maintain this coverage, for instance I terminate employment or switch to a Non-HDHP the next plan year, then the excess funds contributed will be subject to a 10% excise tax.
- Eligible expenses must qualify as a health care deduction under the IRS.
- When I make a mid-year HSA contribution election or enrollment change, I am re-certifying to the terms and conditions.
- In circumstances where my Payment Card is lost/stolen or become aware of fraudulent charges, I will notify ConnectYourCare (CYC) immediately. CYC will deactivate the Payment Card and reissue a new Payment Card.
- If I am found to have used my HSA or Payment Card fraudulently, my participation in the state sponsored HSA may be terminated and I may lose the ability to participate in the state sponsored HSA benefit program in the future.

I certify that:

- The information I have provided is complete and accurate to the best of my knowledge.
- I am covered by one of the qualified IYC HDHP, and that I am not covered by any other non-permitted coverage.
- I have available to me a copy of the application and Custodial Agreement and Disclosure Statement and amendments thereto.
- I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions.

ENROLLMENT TERMS AND CONDITIONS

- I agree to have my compensation reduced by the contribution amount(s) I elected on a pre-tax basis. If I do not wish to have my HSA contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my human resource or benefit office.
- I have reviewed and understand the benefits program eligibility and enrollment information and I agree to abide by all participation requirements.
- All dependents listed meet the eligibility requirements of the program.
- I shall not claim a federal income tax deduction or credit for any expenses that were reimbursed through my HSA.
- I will inform my human resources benefit office as soon as reasonably possible when I am no longer eligible to contribute to the HSA, for instance if I obtain other non-permitted coverage such as coverage under my spouse's plan, and I understand any contributions made for any month in which I am not an eligible individual will be subject to an excise tax, and that my employer will deduct any contributions it made for such an ineligible month from my HSA.
- Use of the Payment Card will comply with the terms and conditions of the Cardholder Agreement received with the Payment Card.
- That all expenses charged on the Payment Card will qualify as reimbursable per IRS rules, will be incurred only for me or my eligible dependents, and will not be reimbursed through any other means, including my or my dependent's insurance plans.
- I will keep all receipts and other documentation related to expenses charged on the Payment Card for account management and tax purposes.
- I understand additional Payment Cards issued to my spouse or dependent(s) will provide the named individual with access to my HSA. I accept responsibility for all card transactions incurred by the named individual and will submit documentation, as requested, for those transactions.
- I acknowledge and agree that use of the Payment Card in violation of this enrollment agreement or the Cardholder Agreement may result in the invalidation and forfeiture of the Payment Card.

Signature _____ **Date** _____

Return this form to your Employer Benefits Specialist or Payroll Benefits Staff.