TOOELE CITY CORPORATION
2019 - 2020 HEALTH SAVINGS ACCOUNT
Enrollment/Change Form

NAME:			SS#	
ADDRESS:	CITY:		STATE:	ZIP:
HOME PHONE NUMBER:	CELL PHONE NUMBER:	DATE OF BIRTH:	E-MAIL:	
COVERAGE DATE:	HDHP DEDUCTIBLE:	COVERAGE TYPE: ❑ SINGLE ❑ FAMILY (INCLUDES 2 PARTY COVERAGE)		

☐ **Check here if this is a change of address**

ADDITIONAL HSA DEBIT CARDS

List spouse and/or dependents with access to your HSA account.
Cards do not expire for three years. Please do not throw away. $10 replacement fee charged.

NAME:	SS#:	DATE OF BIRTH:	RELATIONSHIP TO EMPLOYEE:
NAME:	SS#:	DATE OF BIRTH:	RELATIONSHIP TO EMPLOYEE:

❑ **Re - Enrolling**	
❑ **New Enrollee**	**DATE OF HIRE:** **CHECK DATE OF FIRST PAYROLL DEDUCTION:**
❑ **Notice Of Change**	**REASON FOR CHANGE (Life Event**):** ❑ Marriage ❑ Birth or Adoption of Dependent ❑ Employment Change ❑ Other (explain)_____ ❑ Divorce ❑ Death of Dependent ❑ Benefit Change _____
❑ **Termination**	**DATE OF TERMINATION:** **CHECK DATE OF LAST PAYROLL DEDUCTION:**

HEALTH SAVING ACCOUNT BENEFIT PLAN ELECTION

❑ **Health Savings Account – Employer's Contribution**	*For Employer's Use Only* $ Annual
❑ **Health Savings Account – Employee's Contribution** Total annual contributions (employer and employee) cannot exceed: $3,500 single coverage or $7,000 family coverage.	$ Pay check $ Annual

The employer will make periodic contributions to the HSA plan and remit the employee contributions to the plan. Employee contributions will be made by salary reduction under Sections 105, 106 and 125 of the IRS code. All contributions to the HSA plan become the property of the employee/plan participant at the time the contributions are made.

By signing below I certify that:

1. To open a Health Savings Account I must meet three criteria: 1) I must be covered by a qualified High Deductible Health Plan (HDHP), 2) I cannot be covered by another health plan, including Medicare, and 3) I cannot be claimed as a dependent on another individual's tax return (excluding spouses).
2. Neither I nor my spouse can participate in a HRA or FSA.
3. The UMB Bank will be appointed the custodian of my Health Saving Account.

EMPLOYEE *EMPLOYER*

_____ _____ _____ _____
Signature Date Signature Date