



**TOOELE CITY CORPORATION
2020 - 2021 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: <input type="checkbox"/> SINGLE <input type="checkbox"/> 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:

<input type="checkbox"/> Contribution Change	Complete below Health Savings Account Benefit Plan Election Check date of payroll deduction change _____
<input type="checkbox"/> New Enrollee	Complete below Health Savings Account Benefit Plan Election DATE OF HIRE: _____ CHECK DATE OF FIRST PAYROLL DEDUCTION: _____
<input type="checkbox"/> Notice Of Change	Complete below Health Savings Account Benefit Plan Election REASON FOR CHANGE (Life Event**): <input type="checkbox"/> Marriage <input type="checkbox"/> Birth or Adoption of Dependent <input type="checkbox"/> Employment Change <input type="checkbox"/> Other (explain) _____ <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Dependent <input type="checkbox"/> Benefit Change _____
<input type="checkbox"/> Termination	DATE OF TERMINATION: _____ CHECK DATE OF LAST PAYROLL DEDUCTION: _____

HEALTH SAVING ACCOUNT BENEFIT PLAN ELECTION

<input type="checkbox"/> Health Savings Account – Employer’s Contribution	<i>For Employer’s Use Only</i> \$ _____ Pay check \$ _____ Annual
<input type="checkbox"/> Health Savings Account – Employee’s Contribution Total annual contributions (employer and employee) cannot exceed: \$3,550 single coverage or \$7,100 family coverage. Participants over 55 yrs.old are allow an extra \$1,000 in contributions annually.	\$ _____ 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:

- To contribute into 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).
- Neither I nor my spouse can participate in a HRA or FSA.
- The UMB Bank will be appointed the custodian of my Health Saving Account.

EMPLOYEE

EMPLOYER

Signature

Date

Signature

Date