CHANGE FORM
HEALTH SAVINGS ACCOUNT

(PLEASE PRINT CLEARLY)

245 Kenneth Drive
Rochester NY 14623-4277
Phone: (800) 473-9595
www.BenefitResource.com

Purpose: After a Health Savings Account (HSA) is open and established, use this form:

- To change current payroll deduction amounts for HSA contributions;
- To elect new Plan Year payroll deductions for HSA contributions taken on a tax-free basis through a Section 125 Plan; or
- To make changes in information in the Employee Information section. Note: Name changes and updates to social security number must also be reported to Bank.

This form should be submitted to your employer to be retained for their records. The employer should only submit a copy to Benefit Resource, Inc. if there are changes noted in the Employee Information section.

If you are not yet enrolled in an HSA, please use the HSA Enrollment Form provided to you by your employer.

EMPLOYER:

EFFECTIVE DATE OF HSA ELECTION : / /

A. EMPLOYEE INFORMATION

Member ID: Social Security Number:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / /

Email Address: _____

(Note: Your email address will only be used to communicate with you regarding your HSA program.)

B. HSA PAYROLL CONTRIBUTION ELECTION *Please enter your HSA election.*

Contribution Recommendations

- Level 1: Fund to Deductible (Deductible – Employer Contributions)
- Level 2: Fund to Maximum out-of-pocket (Max OOP – ER Contributions)
- Level 3: Fund to Contribution Limit (Contribution Limit – ER Contributions)

I authorize my employer to initiate the following payroll deduction to contribute to my HSA.

Per Pay Deduction
$ _____

Plan Year Election
$ _____

IRS Contribution Limits

- For 2018: Single Coverage: $3,450; Family Coverage: $6,900
- For 2019: Single Coverage: $3,500; Family Coverage: $7,000

Additional Catch-up Contribution (for those 55 and older): $1,000

The combination of employee, employer and any third party contributions may not exceed this limit.

C. EMPLOYEE CERTIFICATION *Please return completed form to your employer.*

- I understand the eligibility requirements for contributions made to my Health Savings Account and state that I qualify to make contributions to this account.
- I assume complete responsibility for:
  - Determining my eligibility for an HSA each year a contribution is made.
  - Ensuring all contributions made to my account are within the limits set forth by the tax laws.
  - Any tax consequences of contributions (including rollover contributions) and distributions.
- I authorize Benefit Resource, Inc., my employer and/or their third party service providers to exchange information about my identity, enrollment elections, status and other information necessary to facilitate direct deposits to my HSA and to accomplish other purposes related to the payment of healthcare expenses. I agree to indemnify and hold harmless my employer, the Bank, my insurance provider, and their third party service providers against claims or losses that any of them may suffer in reliance on this authorization, and release each of them from any claims or liability based on this authorization.

Signature: _____ Date: _____ / _____ / _____