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MESSA OptionALL

Health Savings Account (HSA) Contribution Program

ELECTION AND SALARY REDUCTION AGREEMENT FORM

Employee name _____
First *Middle* *Last*

Address _____
Street *Apt. / lot #*

_____
City *State* *ZIP code*

Social security number _____ Gender ☐ male ☐ female

Date of birth _____

Employer _____

Pursuant to the terms of my Employer's Section 125 Plan (the "Plan"), I elect to reduce my salary in order to contribute to my Health Savings Account. This amount is to be deducted on a regular basis through normal payroll beginning with the designated plan year and is not to exceed the annual maximum set forth below.

Annual employer contribution: $ _____

Annual employee contribution: $ _____

Total annual contribution: $ 0.00

*The annual maximum per calendar year is the applicable statutory maximum for my High Deductible Health Plan (HDHP) coverage type (i.e., single or family). If applicable, any contributions made by my Employer that are excludable from my income must be subtracted from the statutory maximum in order to determine how much I can contribute annually.

IRS Contribution Limits		
	Single Coverage	Family Coverage
2019	$3,500	$7,000
Note: An additional $1,000 may be contributed for a calendar year if you are 55 or older and are not yet entitled to Medicare.		

Certification: By electing HSA Benefits, I am certifying that I meet the requirements under Internal Revenue Code § 223 to be eligible to contribute to an HSA. (For more information about HSA eligibility requirements, see IRS Publication 969.)

Important HSA Information: I understand that I cannot elect HSA benefits if I am also covered by any non-high deductible health plan, including a health flexible spending account (such as my Employer's Medical Reimbursement Plan), even if elected by my spouse, unless the account is specifically drafted to be HSA-compatible. I understand that I must check any other benefits I have to ensure they do not affect my eligibility for an HSA.

Requirement to Provide HSA Information: By electing HSA benefits, I understand that I must provide sufficient identifying information to facilitate the forwarding of contributions through my Employer's payroll system to our designated HSA trustee/custodian.

I have read and understand the information contained on this form. Moreover, I understand that:

(a) I agree that my cash compensation will be reduced by an amount each pay period during the plan year to cover the cost of the coverages I have elected above.

(b) HSA elections can be changed prospectively on a monthly basis.

(c) This Agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before reduction under the Plan, is at least equal to the amount of that reduction.

(d) If I am a Highly Compensated Employee or a Key Employee, as defined in the Cafeteria Plan, the Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this Agreement to the extent necessary to satisfy certain nondiscrimination requirements of the Internal Revenue Code.

(e) The reduction in my cash compensation under this Agreement shall be in addition to any reductions under other agreements or benefit plans.

(f) The amount of the reduction in my cash compensation for any plan year shall be used only to pay for the benefits I have elected to receive during that plan year. I will not be entitled to receive benefits in any other form.

(g) Prior to the end of the current plan year, I will be offered the opportunity again to elect certain benefits for the following plan year.

I understand that this election will remain in effect in accordance with the rules and procedures of the MESSA OptionALL plan. I MUST complete a new Benefit Election form each plan year.

Date _____ _____

Employee's signature