



Election Form – Health Savings Account (HSA)

General Information:

Employee Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
E-mail Address: _____
Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____
Date of Hire (MM/DD/YYYY): _____

Health Savings Account Election:

2024 HSA Election Maximums: HDHP Single Coverage - \$4,150 Family Coverage - \$8,300
Additional 'Catch-up' allowed for those 55 years of age or older - \$1000

Health Savings Account (HSA)

Glacier Bank Account Number _____ Start Stop
 Health Equity Account Number _____ Per Month Amount \$ _____
Effective Date _____

AUTHORIZATION & ACKNOWLEDGEMENT:

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. I understand that:

- I must be covered by an IRS qualified HDHP to contribute to an HSA.
- I may not be claimed as a dependent on another individual's income tax return.
- I may not be covered by other medical coverage, including Medicare or my spouse's traditional medical Flexible Spending Account.
- HSA benefits cannot be elected in addition to health care flexible spending account reimbursements unless a Limited Purpose FSA option is available.

By acknowledging and submitting this form to Kalispell Public Schools Human Resources, I certify that all of the above statements are true. I understand that I am not eligible to contribute to the HSA during any month in which I do not meet all of the above eligibility requirements. I also understand that the school will forward contributions to my HSA account on my behalf on the basis of this certification and I agree that if I cease to meet any of these conditions, I will immediately notify the KPS HR in writing. Finally, I understand that all contributions are subject to certain aggregate limits under federal tax law. I hereby elect to participate in the Health Savings Account.

Employee Signature

Date