Human Resources Department - Benefits
Independent School District 625
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Saint Paul Public Schools

2027

HSA (Savings Account Election) — Plan Year 2027

Employee ID: **Address:**

First Name: **City:**

Last Name: **Zip Code:**

Election Maximums for 2027:
(Age 55 + May elect an additional $1,000 to the Maximums)
Single $4,500 **Family: $9,000**

Question 1: Is this a new Health Savings Account? ☐ Yes ☐ No (If no continue to Question 2)

If yes I appoint St Paul Public Schools as my agent for the purpose of opening and administering/maintaining an Optum Bank, Inc. ("Bank") Health Savings Account ("HSA") on my behalf and authorize Employer to send and receive information to and from the Bank on my behalf (including account number) in order to accomplish this purpose.

I request the following annual amount to be deducted from my pay: $_____ . 00

- No HSA changes will be accepted or new accounts created in the months of November and December, forms received in January will be effective in February.
- The annual amount elected will be divided equally among paychecks throughout the calendar year (January – December).
- Ten month employees will **not** have deductions during the summer months.

Question 2: Want to change your current annual election amount? ☐ Yes ☐ No (If no continue to Question 3)

$_____.00 **Current** Annual Election Amount

$_____.00 **New** Annual Election Amount (Amount to be changed to)

If yes,to change your annual election, enter the annual amount above. Changes in annual elections are effective the beginning of the following month from the date the form is received in the Benefits Office.
No HSA account changes are accepted in the months of November and December.

Question 3: Want to stop deductions for plan year 2027? ☐ Yes

I am requesting that all payroll deductions are stopped, and I understand that deductions will need to be re-elected during Open Enrollment.

By signing this form:

- I elect to participate in the Saint Paul Public Schools Health Savings Account (HSA) administered by Optum Bank for the 2027 plan year and I authorize Saint Paul Public Schools to deduct the annual amount elected from my pay.
- I hereby consent that all personal information and elections listed above are correct.
- I understand by law a **physical address** is required to open an account, PO Box addresses are not accepted.
- I understand that my enrollment in the HSA disqualifies me from participating in the Healthcare Flexible Spending Account (FSA), but I still may participate in the Dependent Care Flexible Spending Account.
- I further understand that it is my responsibility to notify Saint Paul Public Schools Benefits Office of any HSA Account Closures or Account Number Changes.

Signature: _____ **Date:** _____