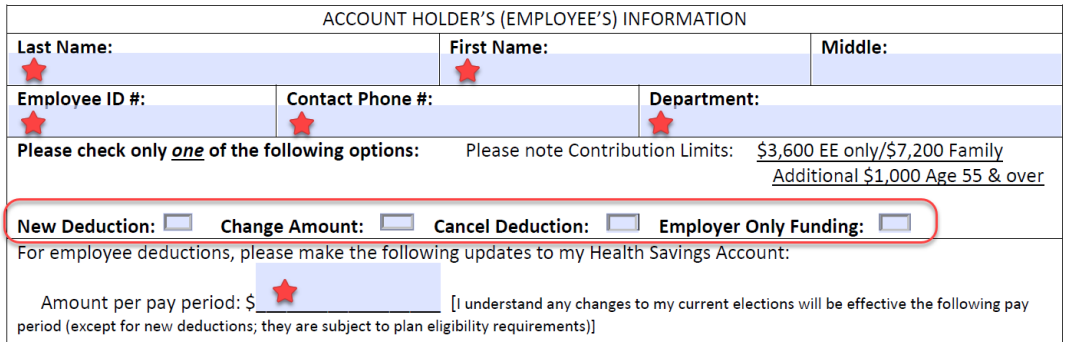
# INSTRUCTIONS: HEALTH SAVINGS ACCOUNT ELECTION FORM

**Please complete the form in its entirety.** Incomplete forms will be sent back for corrections.

## HOW TO COMPLETE THE FORM:

- **Download/Save** this form to your computer. Save as "EEID Name HSA Election Form".
- In the **Account Holder's** section, input your **name**, **EEID**, **phone number**, and **department** information
- Check off either **New Deduction**, **Change Amount**, **Cancel Deduction**, or **Employer Only Funding**
    - **New Deduction –** Begin new contributions. Include your contribution amount in the box below.
    - **Change Amount** – Update (increase/decrease) current contributions. Include your contribution amount in the box below.
    - **Cancel Deduction** – Stop current contributions. Place a **0** (zero) in the box below.
    - **Employer Only Funding** – Select this option if you would like to receive the County employer contribution but do not want to contribute your own funds into the account. The County contribution applies to annual open enrollment elections and to new hire elections.



ACCOUNT HOLDER'S (EMPLOYEE'S) INFORMATION

| Last Name: | First Name: | Middle: |
|---|---|---|
| Employee ID #: | Contact Phone #: | Department: |

**Please check only *one* of the following options:** Please note Contribution Limits: $3,600 EE only/$7,200 Family
Additional $1,000 Age 55 & over

**New Deduction:** ☐ **Change Amount:** ☐ **Cancel Deduction:** ☐ **Employer Only Funding:** ☐

For employee deductions, please make the following updates to my Health Savings Account:

Amount per pay period: $_____ [I understand any changes to my current elections will be effective the following pay period (except for new deductions; they are subject to plan eligibility requirements)]

- Don't forget to insert your **electronic signature** and **date** the bottom of the form.
    - Click review and sign link in email.
    - Click prompt in document.
    - Create signature.
    - Select signature option.
    - Sign document.
    - Finalize signature.
    - Send.

## SUBMISSION PROCESS:

- Submit your completed form to the secure Box.com folder
- Refer to our Upload Documentation webpage for additional information.

## NEED HELP?

- If you need help completing this form please reach out to Benefits@ocfl.net

# 2022 HEALTH SAVINGS ACCOUNT ELECTION FORM

| ACCOUNT HOLDER'S (EMPLOYEE'S) INFORMATION | | |
|---|---|---|
| **Last Name:** | **First Name:** | **Middle:** |
| **Employee ID #:** | **Contact Phone #:** | **Department:** |

**Please check only *one* of the following options:** Please note Contribution Limits: $3,650 EE only/$7,300 Family
Additional $1,000 Age 55 & over

**New Deduction:** ☐ **Change Amount:** ☐ **Cancel Deduction:** ☐ **Employer Only Funding:** ☐

For employee deductions, please make the following updates to my Health Savings Account:

Amount per pay period: $_____ [I understand any changes to my current elections will be effective the following pay period (except for new deductions; they are subject to plan eligibility requirements)]

***By signing below:*** I hereby authorize Orange County Comptroller's Payroll Department to begin, change, or end my HSA employee contribution through Cigna. I understand that I must meet all of the following criteria in order to make contributions to my HSA:

- You must be covered under a high deductible health plan (HDHP)
- You must have no other health coverage that is not a high deductible health plan including TRICARE or TRICARE for Life
- You must not be covered by a general purpose Medical Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA), either yours or your spouse's (you can have a Limited Purpose Spending Account (LPFSA) and will have a separate debit card for this).
- You are not enrolled in Medicare
- You cannot receive VA medical benefits, unless for a service related disability, within the 3 months prior to making a contribution
- You cannot be claimed as a dependent on someone else's tax return (Note: filing married/jointly is not the same as being claimed as a dependent)

I acknowledge that it is *my* sole responsibility to make sure the funds are used for eligible qualifying tax events and that I will be responsible for any taxes incurred if the expense is not eligible. I also understand that Orange County Government and Orange County Comptroller are not liable for any fees incurred by this account. I acknowledge that it is my responsibility (1) to determine whether I am eligible to make contributions to my HSA, and (2) to determine whether or not contributions to this HSA have exceeded the applicable maximum annual contribution limit. For current eligibility guidelines and contribution limits, please visit www.irs.gov under Health Savings Accounts.

**Note: Questions regarding the funds in this account must be directed to Cigna's HSA provider, 1-800-CIGNA24.

**Signature:** _____ **Date:** _____

| **PAYROLL USE ONLY** | Processed by: | Audit: |
|---|---|---|
| HDHP coverage date: | Effective Date: | Paycheck effective date: |


B001 - Beneflex

Reset Form