**\*HSA ONLY**

**Health Savings Account (HSA) Payroll Deduction**

**New Enrollment Change Deduction**

**1. What is this form for?**

**Your employer is offering you the option to contribute to your HSA account pre-tax through payroll deduction. You may also choose to contribute on your own after your HSA account has been opened and take the deduction on your income taxes to the extent appropriate under applicable law. Please list your contribution below.**

**2. Contributor Information**

**Print Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. Signatures**

**I understand the eligibility requirements for the HSA deposit and state that I qualify to make the deposit. I understand that due to banking regulations I will be unable to open or deposit money into an HSA if the address I provided during enrollment is a PO BOX.**

**Signature of Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. Contribution Information**

**I want the following annual amount placed into my HSA account from payroll deduction. (Please see the reverse side of this form for assistance determining your contribution amount.)**

**$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Per Paycheck**

**Sequence, Inc. will allow you to change your Payroll deductions**

**Certification of HSA Eligibility \*HSA ONLY**

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SS#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that in order for **Sequence, Inc**. (the “Employer”) to contribute to a health savings account (HSA) on my behalf, I must meet all of the following HSA eligibility conditions:

**􀂃 I have self-only coverage OR family coverage under the Employer Group Health Plan, which I understand qualifies as a high deductible health plan (HDHP) under Code § 223(c)(2).**

**􀂃 I cannot be claimed as another person’s tax dependent.**

**􀂃 I am not entitled to (enrolled in) Medicare, Medicaid or Tri-Care benefits.**

**􀂃 If I have any health coverage other than my coverage under the Employer Group Health Plan, that coverage is either: (a) HDHP coverage which meets the statutory requirements established by IRC §233(c)(2) and subsequent federal guidance releases; or (b) permitted non-HDHP insurance or coverage (see list of permitted coverage on the reverse side of this form).**

**􀂃 If I am married, my spouse does not have any non-HDHP family coverage such as enrollment in a General Purpose Flexible Spending Account (FSA).**

By signing this form and returning it to the Employer, I certify that all of the statements above are true. I understand that I am not eligible for HSA contributions during any month in which I do not meet all of the above HSA eligibility conditions and I agree that I will notify the Employer immediately in writing, if I cease to meet any of these conditions. I also understand that the Employer will make contributions to an HSA on my behalf on the basis of my certification and that the Employer’s HSA contributions and my own HSA contributions (if any) are subject to certain aggregate limits under federal tax law.

**Employee Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permitted Other Coverage

• Accident or Disability Insurance

• Dental or Vision Insurance

• Long-Term Care Insurance

• Limited Benefit FSA (dental, vision or preventive only)\*

• Limited Benefit HRA (post deductible expenses, suspended HRA or Retiree HRA)\*

• Cancer Policy

• Worker’s Comp

• Tort liabilities

• Hospitalization which pays a fixed amount per day

\*Your spouse may be enrolled in an “employee only” or “employee plus child” Flexible Spending Account –

however, if the spouse is enrolled in a “General Purpose FSA” you are ineligible for HSA account contributions.