

Election Form – Health Savings Account (HSA)

General Information:		
Employee Name:		
Mailing Address:		
City: State:		
E-mail Address:		
Social Security Number:	Date of Birth (MN	И/DD/YYYY):
Date of Hire (MM/DD/YYYY):		
Health Savings Account Election:	<u>.</u>	
2023 HSA Election Maximums: HDHP S	ingle Coverage - \$3,850	Family Coverage - \$7,750
Additional 'Catch-up' allowed for those	e 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 & ACKNOWLED	OGEMENT:	
By electing HSA benefits, I am certifying th	at 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 HD		
• I may not be claimed as a dependent on		
	overage, including Medicare	or my spouse's traditional medical Flexible
Spending Account.	an ta haalth cara flavible car	ending account reimbursements unless a Limited
Purpose FSA option is available.	on to health care hexible spe	ending account reimbursements unless a climited
Tarpose 13/1 option is available.		
By acknowledging and submitting this form	n to Kalispell Public Schools	Human Resources, I certify that all of the above
statements are true. I understand that I a	m not eligible to contribute	to the HSA during any month in which I do not
		he school will forward contributions to my HSA
•		if I cease to meet any of these conditions, I will
		contributions are subject to certain aggregate
limits under federal tax law. I hereby elect	t to participate in the Health	Savings Account.
Employee Signature		

Please return this form to HR. This form is to elect the benefit only. You will be required to complete an application with the bank you choose.