TML MultiState
Intergovernmental Employee Benefits Pool

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HRA HSA
Health Reimbursement Arrangement Health Savings Account

Consumer Centered Employee Enrollment Form

Employer Name	Employer Group #

Social/Member ID # | Last Name | First Name | MI | Date of Birth

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced Date Employed _____

EMPLOYEE ADDRESSES

Street Address

☐ **Check here if new**

Street _____ City _____ State _____ Zip Code _____

Preferred Contact Phone # _____ E-mail _____

Mailing Address

☐ **Check here if new**

Street _____ City _____ State _____ Zip Code _____

HRA OPTION

	Annually	Monthly
☐ Employer Contribution for Health Reimbursement Arrangement	$ _____	$ _____

☐ The benefits of the plan have been thoroughly explained to me and I **decline** to participate.

HSA OPTION

☐ I elect to contribute to my HSA with a pre-tax salary reduction through my employer's Section 125 Cafeteria Plan, and authorize my employer to deduct the amounts as indicated from my salary and forward the funds to IEBP to deposit in my HSA. Contributions made by all parties to Health Savings Account (H.S.A.) cannot exceed the annual HSA limit set by the Internal Revenue Service:

	2018 Annual H.S.A. Contribution Limits	2017 Annual H.S.A. Contribution Limits
Individual	$3,450	$3,400
Family	$6,900	$6,750

☐ Employee Monthly Contribution: $_____ Date of first HSA contribution: ____/____/____

(Date must be on or after the first day of your HSA-compatible health plan coverage or the first day of opening your HSA, whichever is later. Leaving the date blank will authorize your employer to determine the date on your behalf.)

☐ Accountholders must meet all of the qualifications noted below to be eligible to make an additional H.S.A. catch-up contribution of $1,000 above the annual maximum contribution.

- Health Savings accountholder
- Age 55 or older (regardless of when in the year an accountholder turns 55)
- Not enrolled in Medicare (if an accountholder enrolls in Medicare mid-year, catch-up contributions should be prorated)

☐ Total Annual Employee Contribution: $_____ Total Annual Employer Contribution (if applicable): $_____

Note: Your Total Annual Employee Election along with contributions from any other sources, including your employer, may not exceed the Annual Maximum Contribution amount set by the IRS. Contribution limits can be found at: www.iebp.org or by visiting the IRS site at www.irs.gov.

EMPLOYEE ACCEPTANCE

By my signature below, I certify that I have enrolled, or plan to enroll, in an HSA-compatible health plan and that I am not covered under any other plan that would disqualify me from opening or contributing to my HSA. I understand that this form is provided for convenience purposes and that Liberty Health Bank will not initiate contributions to my HSA, but will allow my employer or their authorized agent to initiate contributions to my account.

Employee Signature _____ Date _____

EMPLOYEE DECLINATION

I **DO NOT** want to contribute to my HSA through a pre-tax salary reduction. I understand that I can make after-tax contributions to my HSA online - through Internet Banking (https://www.iebp.org), or by mailing a check with a contribution form.

Employee Signature _____ Date _____

Please return this form to your employer.

WE WANT TO HEAR FROM YOU! Our goal is to provide you with excellent service. Please provide us with feedback. Visit iebp.org/surveys and enter the required fields. Your Security Pin and Survey Type may be found on your EOB. Thank you for your response.