Health Savings Account (HSA) Election Form

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Savings Account. Do not send contributions with this form. By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual," and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

Section 1: Account Holder Information (Please Print)

Name (First, MI, Last) _____

Address **(Physical)** _____ City _____ State _____ Zip _____

Phone (____) _____ Email Address _____

Social Security Number _____ Date of Birth ____ / ____ /____ (mm/dd/yyyy) Personnel # _____

Agency / School _____ HDHP Coverage: ☐ Single ☐ Married ☐ New Hire ☐ Open Enrollment ☐ Update

Section 2: HSA Contributions

I. Annual Employee Contribution $ _____/ 26 Pay Periods

II. Annual Employer Contribution $ _____ $25 Single per month for Annual amount of $300
$50 Married per month for Annual amount of $600

III. **Total Annual Contribution $** _____ *(Line I + Line II, not to exceed Contribution Maximums)*

Section 3: Adoption Agreement / Employee Signature

As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that my benefits administrator is facilitating but not initiating the contribution. If the account is closed at any time, there will be a $25 closing fee.

This application is for the establishment of my individually owned Health Savings Account at the custodian displayed below. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Account Agreement, HSA Terms and Conditions Statement, and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the bottom of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder. I am currently, or will be upon the date of my first contribution, an Eligible Individual as described in the Custodial Account Agreement. I understand that maintaining my eligibility is my responsibility and that the custodian will assume that all contributions are made while I am eligible to do so. I am currently, or will be upon the date of my contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

Signature of Account Holder _____ Date ____ / ____ /____ (mm/dd/yyyy)

Visit ARBenefits Member Portal for online enrollment, or submit the paper form to EBD, by Fax: 501-683-0983, or mail ARBenefits, PO Box 15610, Little Rock, AR 72231, or provide to your HR Rep to submit.
For enrollment questions, please call toll-free at 877-815-1017, or email Ask.EBD@arkansas.gov.

Custodian

DataPath Financial Services
PO Box 55068
Little Rock, AR 72215

Plan Service Provider

Beneliance
www.beneliance.com
Serial No. 666576474227

State of Arkansas Employee Benefits Division

Toll Free: 877-815-1017 | Fax: 501-683-0983
Mailing: ARBenefits
PO Box 15610
Little Rock, AR 72231