Concordia Plan Services
The Lutheran Church—Missouri Synod
PO Box 229007
St. Louis, MO 63122-9007

CONCORDIA PLANS

Toll Free: 888-927-7526
St. Louis: 314-965-7580
Email: info@ConcordiaPlans.org
Website: ConcordiaPlans.org

Health Equity Savings Account Application

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

A Employer/Employee Information

Employer Name:_____ CPS ER#: _____ Plan Year _____

City:_____ State: _____ Zip Code:_____

Employee Name:_____
(Last) (First) (MI)

Street Address:_____

_____
(City) (State) (Zip Code)

Daytime Phone Number:_____ Date of Birth:_____ Member ID: _____

B Health Coverage Information

Type of HDHP Coverage: ☐ Single ☐ Family

Effective Date of Health Coverage: _____

C Annual Election

2024 HEALTH SAVINGS ACCOUNT (HSA) MAXIMUM CONTRIBUTIONS

HDHP Single Coverage - $4,150
HDHP Family Coverage - $8,300
Age 55+ Catch-up - $1,000

I want to contribute $_____ during this Plan Year to my HSA. I understand this amount will be deducted on a pro rata basis from my paycheck throughout the Plan Year.

D Signature

The information entered on this enrollment form is current and correct to the best of my knowledge. I hereby elect to participate in a Health Savings Account and certify that I meet the following eligibility requirements to contribute to an HSA:

- I may not be claimed as a dependent on another individual's income tax return;
- I am covered by a qualified high deductible health plan (HDHP);
- I am not covered by other non-qualified health coverage, including Medicare or a health Flexible Spending Account (other than my or my spouse's limited purpose FSA).

I understand that by enrolling in this HSA, I am accepting the terms of the Custodial Agreement provided to me under separate cover.

_____
HSA Account Holder Signature Date

Please return this form along with other supplementary enrollment forms, if applicable, to your congregational treasurer, business manager, or HR office by the deadline requested by your employer.