

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: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> (Last) (First) (MI) </div> Street Address: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> (City) (State) (Zip Code) </div> 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		
HEALTH SAVINGS ACCOUNT (HSA) MAXIMUM CONTRIBUTIONS			
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> 2025: HDHP Single Coverage - \$4,350 HDHP Family Coverage - \$8,550 Age 55+ Catch-up - \$1,000 </td> <td style="width: 50%; vertical-align: top;"> 2026: HDHP Single Coverage - \$4,400 HDHP Family Coverage - \$8,750 Age 55+ Catch-up - \$1,000 </td> </tr> </table> <p>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.</p> <p>I want to participate in the HSA, but I do not want to make any contributions from my paycheck. I only want the employer contributions to be made to my HSA.</p>		2025: HDHP Single Coverage - \$4,350 HDHP Family Coverage - \$8,550 Age 55+ Catch-up - \$1,000	2026: HDHP Single Coverage - \$4,400 HDHP Family Coverage - \$8,750 Age 55+ Catch-up - \$1,000
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D	Signature		
<p>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:</p> <ul style="list-style-type: none"> - 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). <p>I understand that by enrolling in this HSA, I am accepting the terms of the Custodial Agreement provided to me under separate cover.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%; border-top: 1px solid black; text-align: center;"> HSA Account Holder Signature </div> <div style="width: 15%; border-top: 1px solid black; text-align: center;"> Date </div> <div style="width: 35%; text-align: right;"> <p>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.</p> </div> </div>			