FREEDOM AREASCHOOL DISTRICT

**HSA ELIGIBILITY DETERMINATION / PRE-TAX SALARY REDUCTION ELECTION FORM – Coverage for January 1 – December 31, 2024**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  |  | | | | | | | | |
| First Name | | | MI | L Last Name | | | | | | |
| Social Security # |  |  |  | - |  |  | - |  |  |  |  |

I understand that if I meet the eligibility standards as defined by the IRS, my employer may make a contribution to my Health Savings Account (“HSA”). I may also elect to make pre-tax contributions to my HSA through payroll reductions. These pre-tax contributions are available under my employer’s Section 125 Plan. When making this election, I further understand the 2024 contribution limits for HSAs are $4,150 for Employee Only Plans and $8,300 for Family Plans (with a catch up provision for participants age 55 years and older of an additional $1,000 over the respective category limit). This maximum contribution level is the sum of employer and employee contributions.

**Please make your election below, then sign and date your form and submit it to the Payroll Office:**

I certify that I meet the following requirements and thus am eligible to have a Health Savings Account (“HSA”):

|  |  |
| --- | --- |
| * I am or will be enrolled in Qualified High Deductible Health Plan * I am not enrolled as a dependent in a non-QHDHP coverage | |
| * I am not enrolled in Medicare (Including active employees enrolled in Medicare Part A) * I am not enrolled in TriCare | |
| * I am not claimed as a dependent on another person’s tax return | |
| * I nor my spouse are enrolled in a Medical Flexible Savings Account (FSA) or Health Reimbursement Account (HRA) * I am not receiving Social Security or Railroad Retirement Board Benefits and enrolled in Medicare Part A. | |
|  | |

I understand that I must maintain the eligibility requirements for the current benefit period to remain eligible to ***receive and make contributions*** to my Health Savings Account.

 I am **not eligible**, as defined by the IRS, to be enrolled in a Health Savings Account.

 I **am eligible**, as defined by the IRS, to be enrolled in a Health Savings Account, and I elect to have deducted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per pay period, effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and continuing until I change my election. I understand that my election is prospective only and that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes.

 I **am eligible**, as defined by the IRS, to be enrolled in a Health Savings Account and to receive employer contributions to my HSA; however, I am declining the option to make pre-tax contributions to my HSA at this time.

|  |  |  |
| --- | --- | --- |
| \_ |  |  |

Employee Signature Date