BBP Admin
BENEFITS ADMINISTRATION
COBRA, FMLA, FSA, HRA, HSA, TRANSIT

Section 125 Cafeteria Plan Premium Reduction Option

HSA Benefit Election Form and Salary Reduction Election Form

Employee Name (Last, First, MI) Social Security No.

Employee Street Address City, State, Zip Code

Date of Birth HSA Beneficiary

I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the coverages shown under the HSA, and to deduct from pre-tax income the pre-tax premium checked in the boxes below. Such reductions, considered as elective contributions under the plan, will start with my first paycheck dated after the effective date of the Plan.

I understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that I elect the HSA does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed and to contribute to a HSA I have to be on a qualified HSA plan.

Please select a HSA option below and please indicate what amount you wish to have withdrawn by checking the appropriate box and indicating the amount paid is either pre-tax deduction or after-tax deduction. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan.

Benefits – I would like to enroll in the HSA Plan for the 20_____plan year. ☐ YES ☐ NO

Premium Conversion – Please check all that apply:

☐ HSA Single Medical Coverage Contribution……$_____÷ ___ = $ _____

HSA Only - Maximum Annual Contribution is $3,650

☐ HSA Family Medical Coverage Contribution……..$_____÷ ___ = $ _____

HSA Only - Maximum Annual Contribution is $7,300

☐ HSA Catch-up Contribution (Over 55 years of age)… $_____÷ ___ = $ _____

Maximum Annual Contribution is $1,000

The $1,000 can be two separate amounts for both employee & spouse that are over 55 years of age. Based on a new law if you contribute the $1,000 for you and your spouse your spouse would need to open an HSA account.

MAXIMUM contributions listed above are the most allowed per IRS.
Refer to www.irs.gov for current year HSA Contribution limits.

TOTAL AUTHORIZED REDUCTIONS…… $_____

Note: Per paycheck amount must be equally divided into your annual election. Please adjust your annual election to be an equally divided number.

Eligibility Requirements

Answer the following four questions to determine if you are eligible for a Health Savings Account (HSA)*.

1. I am covered under a Qualified High Deductible Health Plan (QHDHP).	☐**YES**	☐**NO**
2. I am not covered by a health plan, other than a QHDHP, which provides any of the same benefits as the QHDHP.	☐**YES**	☐**NO**
3. I am not eligible for Medicare (age 65) or disability or if I am eligible, I am not enrolled in Part A or B.	☐**YES**	☐**NO**
4. I am not a dependent on another person's tax return.	☐**YES**	☐**NO**

If you answered NO to any of the four questions above DO NOT CONTINUE. You are not eligible to open a Health Savings Account. By signing and submitting this application you affirm your eligibility to establish a Health Savings Account.

*You may open an HSA if you are transferring HSA funds from another custodian even if you answered No to any of the four questions above. However you may no longer be qualified to make additional contributions. We recommend you check with your tax advisor before making further contributions.

I have read the Summary Plan Description and the attached Plan Information Summary for this plan. This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status.

Some fees do apply to the HSA plan. The fees are listed on the Avidia Bank website and can change at any time. If you have any questions about fees please call BBP @ 630-773-2337.

Designated Representative. In its role as Designated Representative, the TPA will serve as primary liaison between the Accountholder and Avidia Bank ("Custodian"). The TPA will not provide any services to the Accountholder or the Accountholder's HSA as a fiduciary under Section 3(21) of ERISA, under any comparable and applicable provisions of state or local law, or under the Investment Advisor's Act of 1940.

By performing services under this agreement, we are acting as your agent. You acknowledge and agree that we are not providing services to you or your HSA as a fiduciary under the Employee Retirement Income Security Act of 1974 ("ERISA") Section 3(21), under any comparable and applicable provisions of state or local law, or under the Investment Advisor's Act of 1940, and nothing in this agreement shall be construed as conferring fiduciary status upon us. We shall not be required to perform any additional services unless specifically agreed to under the terms and conditions of this agreement, or as required under the Code and the applicable guidance with respect to HSAs.

You agree to indemnify and hold us harmless for any and all claims, actions, proceedings, damages, judgments, liabilities, costs and expenses, including attorneys' fees, arising from or in connection with this agreement except for those resulting from our gross negligence or willful misconduct in performance of the services in this agreement. To the extent written instructions or notices are required under this Agreement, we may accept or provide such information in any other forms permitted by law, including through electronic mediums.

Disclaimers. The HSA established by this agreement is intended not to constitute an "employee welfare benefit plan" or an "employee pension benefit plan" as defined by ERISA. Regardless of the status of the HSA under ERISA, we are not an "employer" or "plan sponsor" of the HSA or of any arrangement or plan of which the HSA is a part. We expressly disclaim responsibility for ERISA's participation, vesting, funding, reporting, disclosure, and fiduciary requirements as they may apply to your HSA, including but not limited to any requirement to provide notices or election forms regarding continuation coverage under ERISA. If and to the extent that the HSA is deemed to be part of an arrangement or plan subject to ERISA, including any determination that the HSA is subject to ERISA's continuation coverage requirements, this agreement may be amended or terminated at our sole discretion as of the effective date of such determination or on such later date, as we deem appropriate.

To Authorize Participation: I hereby certify the above information to be correct and true and choose to participate.

Signature_____ Date_____

Form of Identification: □ Driver's License □ State ID □Passport ID

Number:_____

E-Mail Address **(Required for Online Banking and E-Statements):**_____@_____

Home Phone#_____Business Phone#_____

125 West Orchard Street - Itasca, Illinois 60143-1764

Phone (630) 773-2337 – Fax (630) 775-8568 – E-mail support@bbpadmin.com

BBP Admin
BENEFITS ADMINISTRATION
COBRA, FMLA, FSA, HRA, HSA, TRANSIT
info@bbpadmin.com
www.bbpadmin.com
630 773 2337