FlexBank|Navia Health Savings Account & Flexible Spending Account

Section I. Employee Information

Employer Name:		Plan Year:	Division #:
Employee Name:	☐ Male ☐ Female	Social Security #:	
Street:	City:	State:	Zip:
Birth Date:	Hire Date:	HDHP Effective Date:	# Pay Periods:

Section II. Group Insurance Premium and/or HSA Contribution

Your Group Insurance plan premiums and/or Health Savings Account contributions are withheld pre-tax automatically. Your election to pay your Group Insurance premium and/or Health Savings Account contribution automatically continues each year unless revoked. You may revoke your premium election at the beginning of a plan year or during the year should you have a qualifying "life event" that permits a mid-year change.

Section III. HSA Contributions

2020: Single $3,550 Family $7,100 ~ If 55 and older, additional annual catch up contribution is $1,000.
2021: Single $3,600 Family $7,200 – If 55 and older, additional annual catch up contribution is $1,000

Full HSA contribution regardless of month individual becomes eligible. Individuals who become covered under an HSA-eligible plan in a month other than January may make the maximum HSA contribution for the year based on their coverage in the last month of the year. If an individual does not stay in the HSA-eligible plan 12 months following the last month of the year of the first year of eligibility, the amount which could not have been contributed except for this provision will be included in income and subject to a 10 percent additional tax.

Ineligible Mid-Calendar Year. If an individual becomes covered by other first dollar coverage and/or terminates HSA-eligible coverage during a calendar year, the maximum contribution is prorated based on the number of months they are eligible in that calendar year. However, HSA contributions may be changed anytime during the year.

$ _____ per pay

Section IV. FSA Health Care Account – Please Choose One: Maximum $_____

☐ I do not wish to participate.	**General Purpose** I do not and will not contribute to a Health Savings Account (HSA) in my name; nor does my spouse contribute to an HSA. I elect: ☐ General-purpose FSA for medical, vision and dental expenses.	**Limited** I contribute and / or my spouse contributes to a Health Savings Account. I elect: ☐ Limited FSA for vision, dental, post-deductible medical expenses.	$ _____ per pay $ _____ per year

Section V. Work Related Dependent Child (up to 13th birthday) and/or Adult Day Care Reimbursement Account

In order to participate in the Dependent Care Spending account, you must meet the following criteria:

- You and your spouse must both be working, seeking gainful employment or be a full-time student to be eligible to participate in the plan.
- Your contribution may not exceed your earned income, nor your spouse's earned income.
- In the situation of divorce, only the Custodial parent may use this account.
- If you are single or are married/filing a joint tax return, the maximum permissible election per calendar year is $5,000. If you are married/filing separately, the maximum is $2,500 per calendar year.
- You may change your dependent care election if you have a change in status such as a change in cost or change in provider. Changes must be made within 30 days of the event.

$ _____ per pay

$ _____ per year

Section VI. Authorization

- **These are my pre-tax elections. I have read and understand the description of the plan.**
- **I understand that if I own an HSA, I am responsible for knowing and abiding by all of the rules and regulations.**
- **I certify I am eligible to contribute to a health savings account.**
- **I understand my insurance premium and Health FSA election may only be changed during the Plan Year for certain "life events" such as marriage, divorce, death of a spouse or child, birth or adoption of a child, change in employment status, or termination of employment. Changes must be made within 30 days of the event.**
- **Health savings account changes in election may be made at any time.**
- **Participation in this program may reduce my future Social Security benefits.**
- **I understand that unused balance left in my Health FSA and/or Dependent Care FSA at the end of the Plan year cannot be returned to me.**
- **I authorize my employer to make automatic payroll deductions of the amounts shown above from my earnings each pay period as well as authorize FlexBank to debit/credit my health savings account as necessary for HSA depositing.**

Date _____ **Employee Signature** _____

Section VII. To Be Completed By Employer

Effective date of Participation:	Date of 1st payroll deduction:	Phone: 937.299.5515 ~ Free:888.677.8373 *Revised May 2020*