HSA Enrollment

State of Utah

This packet contains forms
and instructions for enrolling
in a Health Savings Account.

Step-By-Step Eligibility and Enrollment Instructions

Employee Health Savings Account (HSA) contributions **will not begin** until the HSA enrollment forms have been completed and received by PEHP. Follow these steps and return completed forms to PEHP.

STEP 1 – Fill out the **Health Savings Account Eligibility Checklist**.

» This will determine if you are eligible for a Health Saving Account.

STEP 2 – Complete the **Payroll Deduction Election & Limited Purpose FSA Enrollment Form**.

» Fill out the Limited FSA Election section only if you wish to have the Limited FSA with your HSA.

STEP 3 – Enroll in an HSA and set or change your contributions straight from your paycheck at www.pehp.org (log in to the Members Section).

You will receive an HSA benefit card from HealthEquity. If you have enrolled in a limited purpose flexible spending account (FSA), you will receive an FSA benefit card from Metavante.

PEHP Serving the Employees Who Serve Utah

Health Savings Account Eligibility Checklist

Am I eligible to enroll in a Health Savings Account?

To be eligible for the HSA, you must enroll in The STAR Plan. Also, the following things must apply to you:

- ☐ You're not participating in or covered by a flexible spending account (FSA) or HRA or their balances will be $0 on or before June 30.
- ☐ You're not covered by another health plan (unless it's another HSA-qualified plan).
- ☐ You're not covered by Medicare.
- ☐ You're not a dependent of another taxpayer.

If you checked all of the boxes above, you're HSA eligible and can begin the process of enrolling in The STAR Plan and an HSA.

If you cannot check all of the boxes listed above then you are most likely not eligible for an HSA. You may enroll in The STAR Plan only but you will not be able to establish an HSA.

Other Health Coverage

You (and your spouse, if you have spouse or family coverage) generally cannot have any other health coverage that is not HSA-qualified. However, you can still be an eligible individual even if your spouse has non-HSA-qualified coverage provided you are not covered by that plan.

You can have additional insurance or coverage for the following items:

- » Accident.
- » Disability.
- » Dental Care.
- » Vision Care.
- » Long-term Care.
- » Insurance for a specific disease or illness.
- » A fixed amount per day (or other period) of hospitalization.
- » Liabilities incurred under workers' compensation laws, tort liabilities, sor liabilities related to ownership or use of property.

For questions or further information, contact PEHP FLEX$ Department at 801-366-7503 or 800-753-7703 or HealthEquity at 866-960-8058.

Public Employees Health Program, HSA Accounts
560 East 200 South, Suite 100, Salt Lake City, Utah 84102-2004
801-366-7503 TOLL FREE 800-753-7703
FAX 801-366-7772 TOLL FREE 800-759-8772

State of Utah
HSA Benefit Card Agreement
Limited FSA Enrollment Form

PLAN YEAR FROM JULY 1 TO JUNE 30

EMPLOYEE INFORMATION			
EMPLOYEE NAME (last, first, middle initial)		SSN#	**PLAN YEAR:**
HOME ADDRESS	CITY/STATE/ZIP		DAYTIME PHONE
Employee High Deductible Health Plan (HDHP) Enrollment Date:			Email:

HEALTH SAVINGS ACCOUNT ELECTION (Health Equity)

FUTURE HSA CONTRIBUTIONS FROM MY SALARY (optional)	Amount
Total amount to be withheld per pay period, beginning the next possible pay period	

Limited Purpose FSA Card Agreement

☐ **Send me a LFSA Benefit Card**

The first two cards are free. All additional cards are $10 each.

Additional Cards (Limited FSA)

Designation	Full Given Name of Eligible Person	Send Card
Spouse		☐
Dependent		☐

LIMITED FSA ELECTION

	Per pay period
Qualified Limited FLEX$ Account	$
Qualified Dependent Day Care Account	$

New Hire *

Employee Hire Date: ____________________

Mid Year Changes after July 1*:

Qualifying Event/Status Change Date____________

Marriage	Employment Status Change
Divorce	Employment Change of Spouse
Death of Spouse or Child	Dependent Status Change
Birth or Adoption of Child	Other

Explain in detail or attach appropriate Documents: ____________

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***New hire enrollment/ mid-year changes must be made within 60 days of the qualifying event**

Benefit Card Agreement

I hereby, authorize my employer to reduce my gross salary in the amounts designated above and contribute the amounts to the designated HSA and/or limited FLEX$ account. I agree to contribute the amount designated per pay period to cover this election amount. I promise and agree to repay the administrator for all amounts paid in excess of that which I have elected. I acknowledge that the salary reduction amount will not exceed my gross salary for that same period. Should a deduction fail to be made, on the pay period following the effective date, I will contact the Plan Administrator no later than the next pay period. Failure to take such corrective action will cancel my participation in the limited FSA for the remainder of the current Plan Year. I acknowledge and understand that the deduction reflected here in is irrevocable, except as provided for in the respective Plan Handbook (available at www.pehp.org) which I have received and read.

I acknowledge that the Plan Administrator shall pay or reimburse approved expenses from the appropriate account(s) up to the maximum annual elected amount. Any amounts in my Limited FSA account not properly claimed or used by me shall be forfeited to my employer. I certify that the dependents for whom I will submit claims are eligible dependents according to Section 152(a) of the IRS Code. I also certify that any expenses paid, using the administrator issued Flex Spending Card, will be for eligible dental and vision expenses for myself, my spouse and/or my eligible dependents and that such expenses have not and will not be reimbursed under any other Flexible Spending Plan, insurance plan, HSA, HRA or claimed as a deduction on a tax return. I understand that if I have an HSA, my limited FSA can be used for preventative, dental and vision services only. I understand that to participate in the Limited FSA, I must be enrolled in a HDHP and HSA.

I authorize PEHP and affiliated organizations to release personal information, including personal health information, about me, my spouse and/or my dependents, as necessary to process claims and to administer the 125 Flexible Benefit Plan .

EMPLOYEE SIGNATURE	DATE	PEHP APPROVAL

Unsigned claims will not be processed.