

State of Arkansas HSA Election Change Form

Follow these easy steps:

1. Complete all entries on this Enrollment Form. Please print.
2. Sign and date this form.
3. Submit it to your Human Resources Department

For Employer Use	
Date of Hire (MM/DD/YYYY)	<input type="text"/>
Benefits Effective Date (MM/DD/YYYY)	<input type="text"/>

Personal Information

Employee Name (last name, first name)	<input type="text"/>	Social Security Number	<input type="text"/>
Street Address (cannot be PO Box)	<input type="text"/>	City, State, Zip Code	<input type="text"/>
Mailing Address (if different)	<input type="text"/>	City, State, Zip Code	<input type="text"/>
Day Time Phone Number	<input type="text"/>	Email Address	<input type="text"/>
Date of Birth (MM/DD/YYYY)	<input type="text"/>		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			

Health Savings Account Qualification

Your Health Savings Account is your financial asset even if you change employers or health plans. To open a Health Savings Account through the State of Arkansas benefits program, you must meet three criteria:

- 1) You must be enrolled in the AR Classic Plan or AR Basic Plan.
- 2) You cannot be covered by another health plan, including Medicare or Flexible Spending Account. (You may be covered by a Limited Use Flexible Spending Account or Limited Use Health Reimbursement Arrangement.)
- 3) You cannot be claimed as a dependent on another individual's tax return.

Health Savings Account (HSA) Contribution Change Request

I elect to change my HSA contribution amount per pay period to \$_____, effective the next available pay period.

I elect to restart contributions to my HSA account in the amount of \$_____ per pay period, effective the next available pay period.

I elect to stop all contributions to my HSA account effective the next available pay period. I understand I may restart HSA contributions at any time if I am eligible to do so by completing a new HSA Election Change Form.

Authorization and Certification

I accept the terms of the ConnectYourCare HSA enrollment form. I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified. I understand the HSA election I have made will remain in place from year-to-year until I notify my employer of a change to my HSA election.
- I must report any administrative errors to my payroll administrator or HR department within 10 days of my first payroll deduction of the plan year.

I will receive a ConnectYourCare Payment Card to access funds in my account. I certify that:

- The card will only be used for eligible medical expenses.
- Claims I pay with the card have not been reimbursed and I will not seek reimbursement from any other plan covering health or dependent care benefits.

Employee Signature

Date

*The total combined amount of both employer and employee contributions cannot exceed IRS maximum contribution limits. For 2021, the limits are \$3,600 for self-only coverage, and \$7,200 for family coverage. There is an additional \$1,000 'catch-up' contribution amount available to those age 55 and older.

IRS regulations are indexed annually for inflation. If you want to contribute the total annual amount for a tax year in which you were only HSA eligible for a portion of that year, you must remain HSA eligible through the end of the next tax year or face tax penalties.