



Optum Financial® HSA Enrollment Form

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"/>
Department Information	
Department Name	<input type="text"/>
Department Number	<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"/>	Enrollment Status	New enrollment <input type="checkbox"/> Re-enrollment <input type="checkbox"/>
Marital Status	Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>		

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 ARBenefits Classic Plan or ARBenefits 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)	
<input type="checkbox"/> Select HSA <input type="checkbox"/> Decline HSA	Annual Employer Contribution <input type="text"/>
I. Annual Employee Contribution (Not to Exceed Contribution Maximums*)	<input type="text"/>
II. Number of regular pay periods	<input type="text"/>
III. Contribution per pay period (I divided by II)	<input type="text"/>

Authorization and Certification	
I accept the terms of the ConnectYourCare HSA enrollment form. I understand that:	
<ul style="list-style-type: none"> • 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:	
<ul style="list-style-type: none"> • 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 _____	<input type="text"/> Date

*The total combined amount of both employer and employee contributions cannot exceed IRS maximum contribution limits. For 2024, the limits are \$4,150 for self-only coverage, and \$8,300 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.