



CITY OF WEST ALLIS
MARCH 1, 2016 – FEBRUARY 28, 2017
HEALTH SAVINGS ACCOUNT (HSA) FOR DIRECT DEPOSIT

RETURN THIS FORM ONLY IF YOU ARE ELECTING TO PARTICIPATE IN AN HSA IN CONJUNCTION WITH THE HIGH DEDUCTIBLE HEALTH PLAN (HDHP).

I. GENERAL INFORMATION

EMPLOYEE # _____

EMPLOYEE NAME: _____

MAILING ADDRESS: _____
 (STREET)

_____ (CITY) _____ (STATE) _____ (ZIP)

PHONE NUMBER: _____ (____) _____

SOCIAL SECURITY #: _____

II. HEALTHCARE SAVINGS ACCOUNT- RETURN THIS FORM BY 5:00 P.M. WEDNESDAY, FEBRUARY 10, 2016.

For 2016, the maximum amount that can be contributed to an HSA from ALL SOURCES is \$3,350 (single) and \$6,750 (family). If 55 or over, an additional \$1,000 is allowed. Funds carryover from year to year. For 2016, the City of West Allis will contribute \$500 (single) and \$1,000 (family). Unlike a Flexible Spending Account, sufficient funds must be available in your HSA to pay healthcare expenses.

_____ I hereby elect to participate in the Healthcare Savings Account as indicated below. **(NOTE: You must be enrolled in a HDHP in order to participate; this account is not available to individuals who participate in other health insurance such as a spouse's plan, Medicare Parts A and/or B, Medicaid, Title 19, or are claimed as a dependent on someone else's tax return.)**

As a participant I hereby elect to participate in the HSA Plan and authorize the City of West Allis to reduce my wages on a **pre-tax** basis during each payroll period in the following amount. I understand this election must be re-authorized each year.

	PER PAY PERIOD	X	# PAY PERIODS	=	ANNUAL ELECTION
HSA-SINGLE	\$ _____	X	_____	=	\$ _____

(Max is \$3,350-\$500 City contribution = \$2,850/26 = \$109.60)

	PER PAY PERIOD	X	# PAY PERIODS	=	ANNUAL ELECTION
HSA-FAMILY	\$ _____	X	_____	=	\$ _____

(Max is \$6,750-\$1,000 City contribution = \$5,750/26 = \$221.15)

My pay schedule is bi-weekly.

III. AUTHORIZATION AND ACKNOWLEDGMENT

I understand that I can withdraw funds from my HSA at any time, but only as long as there are sufficient funds in my account. I further understand that if the funds are withdrawn for any expense other than a qualified medical expense, the IRS will impose a 20% penalty tax. I acknowledge that it is my responsibility to maintain a record of the expenses sufficient to demonstrate that the distributions were for qualified medical expenses.

DATE _____ EMPLOYEE SIGNATURE _____

RETURN this ENROLLMENT FORM to the FINANCE DEPARTMENT
Questions? Contact LAURELL KOHLER (x8246) or MELISSA WEISNIGHT (x8261)



Health Savings Account (HSA) Application Information

Account Owner Information***

Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

Phone Numbers: (H) _____ (W) _____

Additional Related Products (check applicable boxes):

- Checks (first order free)
- Debit Card (free)
- Online Banking (free)
- Online Statements (free)

*****If not a current TCNB customer, please attach photocopy of account owner's picture identification (i.e. valid WI Driver's License/State ID, US Passport, Gov't/Military ID or Resident Alien Card)*****

The undersigned gives this information to obtain a Tri City National Bank EZPay Health Savings Account Debit Card. I certify this information is true and complete and authorize Tri City National Bank to verify it, obtain more information on my financial responsibility, and furnish the same to others. I agree to use the EZPay Health Savings Account Debit Card (if issued) according to the rules provided by Tri City National Bank. I understand that the Internal Revenue Service (IRS) limits the use of the Health Savings Account to qualified medical expenses and that any non-qualified expenditures must be reported to the same (IRS).

Accountholder's Signature

Today's Date

Agent (Authorized Signer) Information

Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

Phone Numbers: (H) _____ (W) _____

Additional Related Products (check applicable boxes):

- Debit Card (free)
- Online Banking (free)

Death Beneficiary Information
(Minimum of one beneficiary must be named)

HSA Death Beneficiary #1

Name: _____

Address: _____

DOB: _____

SSN: _____

Relationship: _____

Share %: _____

Circle Beneficiary Type: Primary or Contingent

HSA Death Beneficiary #2

Name: _____

Address: _____

DOB: _____

SSN: _____

Relationship: _____

Share %: _____

Circle Beneficiary Type: Primary or Contingent

HSA Death Beneficiary #3

Name: _____

Address: _____

DOB: _____

SSN: _____

Relationship: _____

Share %: _____

Circle Beneficiary Type: Primary or Contingent

HSA Death Beneficiary #4

Name: _____

Address: _____

DOB: _____

SSN: _____

Relationship: _____

Share %: _____

Circle Beneficiary Type: Primary or Contingent

HSA Death Beneficiary #5

Name: _____

Address: _____

DOB: _____

SSN: _____

Relationship: _____

Share %: _____

Circle Beneficiary Type: Primary or Contingent

HSA Death Beneficiary #6

Name: _____

Address: _____

DOB: _____

SSN: _____

Relationship: _____

Share %: _____

Circle Beneficiary Type: Primary or Contingent