



HSA Election

Employee Information

First Name: _____ MI: _____ Last Name: _____

Health Savings Account Contribution Limits: The 2018 annual HSA contribution limit for individuals with self-only HDHP coverage is \$3,450, and the limit for individuals with family HDHP coverage is \$6,900.

I authorize my employer to make the following salary reductions:

Health Savings Account: I elect to have \$_____ deposited annually into my Health Savings Account.

I understand that by signing this Election Form I am authorizing any necessary pre-tax deductions required to pay for above elected benefit selections.

Employee Signature Date

FSA Election

Employee Information

First Name: _____ MI: _____ Last Name: _____

Flexible Spending Accounts

I understand that:

- I cannot change Flexible Spending Account deductions during the Plan Year unless I have a change in family status.
- Any amounts remaining in my Flexible Spending Account at the end of the Plan Year, after all claims have been processed, will be forfeited.
- My Social Security benefits may be reduced by this election.
- This election replaces any previous elections, and will terminate on the earlier of: (1) the end of the Plan Year, (2) when I am no longer a qualified employee eligible to participate in the Plan, or (3) termination of the Plan,
- My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I authorize my employer to make the following salary reductions:

Flexible Spending Health Care Reimbursement Account:

I elect to have \$_____ annually (\$2,550 maximum)*

Dependent Care Reimbursement Account:

I elect to have \$_____ annually (\$5,000 maximum)*

Employee Signature Date