Employee ID_____
(Required)

2017 HSA Certification Form

Employee Information

Please make sure your personal information is up to date to ensure timely delivery of any necessary communications sent by the Benefits Office throughout the 2017 Plan Year.

Changes to your home address, phone number, emergency contact(s), and/or self-identification data can be updated in HRMS by navigating to Self Service > Personal Information > Personal Information Summary. If you do not have access to a computer, please call ASK URHR (275-8747) for assistance.

Name (Last, First, Initial) ***Please Print****:* _____

Daytime Phone #:_____**Date of Birth:** _____

Health Savings Account (HSA) Eligibility Criteria

To determine your ability to enroll in a Health Savings Account per the IRS Guidelines and receive the University's Employer Funding ($200 single coverage/$400 family coverage) you will need to meet ALL the requirements below.

- ✓ You must elect coverage under the University's YO**UR** HSA-Eligible Plan for 2017.
- ✓ You cannot be covered by any other health plan (including spousal health insurance), except what the IRS permits.
- ✓ You cannot elect nor be covered by another person's Health Care Flexible Spending Account or Health Reimbursement Arrangement for 2017.
- ✓ You cannot be enrolled in any part of Medicare, Tricare, Medicaid or state health care programs.
- ✓ You cannot or will not be claimed as a dependent on another person's tax return for 2017.
- ✓ You cannot have received Veteran's Administration health benefits in the past 90 days (preventive, dental and vision is permitted).

☐ I declare that I **do not** meet all the requirements above to the best of my knowledge

☐ I declare that I **do** meet all the requirements above to the best of my knowledge

Signature: _____

If you do not meet the requirements to enroll in a Health Savings Account you may choose to enroll in a Flexible Spending Account

Health Savings Account (HSA)

If you wish to contribute to a Health Savings Account in 2017, please complete this section. 2016 contribution elections will not automatically rollover.

☐ Health Savings Account (Min $100, Max $3,400 with single University's YO**UR** HSA-Eligible Plan coverage, Max $6,750 with family University's YO**UR** HSA-Eligible Plan coverage. If you are age 55 or older you may contribute an additional $1,000)
Annual Health Savings Account contribution of $_____

Please return completed forms to: Benefits Office, 44 Celebration Dr., Suite 2300, P.O. Box 270453, Rochester, NY 14627; Fax: 585-273-1054 or Email: benefitoffice@hr.Rochester.edu

Employee ID_____
(Required)

Important Notice: When Open Enrollment ends on November 15, 2016, you will not be able to make changes to your benefit plan elections (except for HSA contribution amounts) unless you have a Qualifying Event. (Please see the Health Program Guide for details.) You will receive a confirmation statement in the mail of your 2017 benefits elections mid-December.

Authorize Elections and Certify Dependent Eligibility

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and each of my family members who are covered under the Plans are bound by the terms and conditions of the plan documents and associated administrative documents as from time to time are in effect and that these documents have been available (and will continue to be available) to me online at www.rochester.edu/benefits or in hard copy at the University of Rochester Benefits Office. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information to the Plan's Third-Party Administrators and insurance carriers. I make this acknowledgement and agreement on behalf of myself and each person who now or in the future accepts coverage under the terms of the Plan applicable to my coverage (who may include, for example, my spouse, and my eligible family dependents).

I authorize the University to deduct from my wages or salary the amount(s) indicated on the University of Rochester 2017 Health Care and Dental Plans Premium Rate Sheet to pay my share of the cost of being covered by University benefit plans I have elected. I understand that such pay deductions will generally be taken on an after-tax basis, with the exception of premium contributions toward the cost of Health Care Plan coverage for tax-qualified dependents, flexible spending accounts (FSA) contributions, or Health Savings Account (HSA) contributions, which will be taken on a before-tax basis. I understand that if I am enrolled in coverage through the University and not receiving paychecks from the University, I must continue to pay my share of the premium for the Health Care and Dental Plan coverage to continue coverage through the University. If the University does not receive payment for the coverage, the coverage will be terminated on the last day of the month in which the premium has been paid in full and notification of the coverage cancellation will be sent to the home address from the University. Employees whose coverage has been canceled due to non-payment will not be eligible to re-enroll in Health Care or Dental Plan coverage until the next Open Enrollment period and until the premiums past due are paid to the University. Employees returning to work with an outstanding balance will be subject to arrears billing.

By electing an FSA or HSA, I and the University of Rochester, hereby agree that my cash compensation will be reduced by the annual amount set forth in the FSA or HSA section of this form, pro-rated by the number of pay periods in 2017 (or by the number of pay periods remaining after the date of this agreement) and deducted from my pay in equal installments. I have read and understand the information contained in the Flexible Spending Account Election of Reimbursement & Compensation Reduction Agreement.

I understand that if I have knowingly included any false information or enrolled ineligible dependents, that coverage may be cancelled, upon one month's written notice and any benefit claims may be denied, and that I may be subject to disciplinary action including termination of employment to the extent permitted by law. I have read and understand the information defining dependent eligibility under the University of Rochester Health and Dental Plans. I certified that each of my dependents covered under my health care and/or dental plan(s) meet the University's current dependent eligibility requirements, and that I agree to notify the Benefits Office if their status changes during the plan year.

Signature:_____ **Date:** _____

If you have any questions, please contact the Benefits Office at (585)275-2084.

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