Health Savings Account (HSA)
2023 Salary Reduction Election and Certification of HSA Eligibility
City of Traverse City

Name: _____ Employee #: _____

Address: _____

Effective _____, 2023 I hereby authorize $_____ (biweekly amount) to be reduced from my pay on a pre-tax basis under my employer's flexible benefits plan and deposited into my Health Savings Account. I understand that it is my responsibility to comply with Internal Revenue Service (IRS) regulations regarding deposit amounts into my Health Savings Account.

Contribution and Out-of-Pocket Limits for Health Savings Accounts and High-Deductible Health Plans

HSA contribution limit (employer + employee)	Self-only: $3,850 Family: $7,750
HSA catch-up contributions (age 55 or older)	$1,000

(NOTE: The employer contributions will need to be included in contribution limits)

I also understand that for any month contributions made to a health savings account (HSA) on my behalf, I must meet all of the following HSA eligibility conditions:

1. I have high deductible health plan (HDHP) coverage under my employer's health plan.
2. I cannot be claimed as another person's tax dependent.
3. I am not enrolled in Medicare.
4. If I have any health coverage other than my employer's HDHP, that coverage must be either: (a) other HDHP coverage; or (b) permitted non-HDHP coverage (coverage for accidents, disability, dental care, vision care, or long-term care; insurance in which substantially all of the coverage relates to liabilities under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., home-owner or auto insurance), or similar liabilities specified by the IRS; insurance for a specified disease or illness (e.g., cancer insurance); or insurance that pays a fixed amount per day of hospitalization).
5. If I am married, I am not covered by my spouse's health plan unless that coverage qualifies under a non-HDHP plan, or for any month your spouse participates in a general-purpose health flexible spending arrangement (FSA) or health reimbursement arrangement (HRA) through his or her employer.

By signing below, I certify that all of the statements above are true. I understand that I am not eligible for HSA contributions during any month in which I do not meet all of the above HSA eligibility conditions. I also understand that my Employer's HSA contributions and my own HSA contributions (if any) are subject to certain limits under federal tax law and that it is my responsibility, not my Employer's, to ensure those limits are met.

_____ _____

Employee Signature Date

****You may wish to consult your tax advisor to determine what HSA contributions are best for you****