Healthcare Account Enrollment Form

KELLY
& ASSOCIATES
INSURANCE GROUP

Please Remember:
- Your employer may offer only one or a combination of the accounts listed below.
- You may select only the account(s) your employer offers.
- Print clearly.
- Sign and date the form.

Personal Information

Employee Name (last name, first name)		Social Security Number	
Mailing Address (can not be a P.O. Box)			

Plan Election Information

Health Savings Account (HSA)*

☐ Select HSA

I. Annual Contribution (Maximum Total Contribution**: $2,900 single coverage; $5,800 family coverage)	
II. Number of regular pay periods	
III. Contribution per pay period (I divided by II)	

☐ Check here if you are an owner of the company.

Information for owners:
If you would like to participate in an HSA, please check the box to the left to enroll and write "0" in the contribution amount boxes. Then, make your contributions directly from your personal bank account via the ConnectYourCare CDH Portal and not through payroll deductions.

Flexible Spending Account (FSA)

☐ Select FSA

(If choosing both HSA and FSA, the FSA becomes limited use, covering dental & vision expenses only)

I. Annual Contribution (Not to exceed maximum set by employer)	
II. Number of regular pay periods	
III. Contribution per pay period (I divided by II)	

Dependent Care Assistance Plan (DCAP)

☐ Select DCAP

I. Annual Contribution (Maximum Contribution: $5,000)	
II. Number of regular pay periods	
III. Contribution per pay period (I divided by II)	

Beneficiary Information (for HSA only)

Primary Beneficiary		Relationship	
Secondary Beneficiary		Relationship	

Authorization and Certification

I understand that:
- I am authorizing my employer to reduce my compensation by the amount specified. This election will expire at the end of the plan year, and I must make a new election each year.
- I am not permitted to change my FSA or DCAP elections during the plan year unless the change is due to and in accordance with certain recognized IRS regulations for change in status events.
- 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.
- Any funds left in my Flexible Spending and/ or Dependent Care Accounts at the close of the plan year will be forfeited.
- I accept the terms of the ConnectYourCare HSA enrollment form and the UMB Bank, N.A. Custodial Agreement.

I will receive a ConnectYourCare Payment Card to access funds in my account. I certify that:
- The card will only be used for eligible medical and/ or dependent care 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 ______________________ Date ______________

*Your Health Savings Account is your financial asset even if you change employers or health plans.
To open a Health Savings Account you must meet three criteria:
1) You must be covered by a qualified high deductible plan.
2) You cannot be covered by another health plan, including Medicare or a 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.

** Maximums shown refer to 2008 statutory HSA contribution limits, as set by the IRS. Maximums include both employer and employee contributions; the total combined amount cannot exceed the maximum contribution limits. Maximums do not include additional "catch-up" amounts available to individuals 55 or older. For 2008, this catch-up amount is $900.

Print Form

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