

FRANKLIN COUNTY COMMUNITY SCHOOL CORPORATION
225 E. 10TH STREET
BROOKVILLE, INDIANA 47012

HSA PAYROLL DEDUCTION FORM

You have elected to remain/enroll in a HDHP Health/Rx Plan.

If you are eligible, a Health Savings Account will be opened in your name, and Franklin County Community School Corporation will make a contribution into the Health Savings Account on your behalf according to your election.

IRS regulations state that individuals entitled to Medicare cannot contribute to a Health Savings Account. If an employee chooses a family HSA Insurance Plan, Franklin County Community School Corporation will contribute \$1,000 towards your contribution of the premium, and the remainder of the premium will be divided into the appropriate number of pays for a payroll deduction. If an employee chooses a single HSA Insurance Plan, Franklin County Community School Corporation will contribute \$500 towards your contribution of the premium, and the remainder of the premium will be divided into the appropriate number of pays for a payroll deduction.

Please contact FIRST FINANCIAL BANK at (765)647-3591 to establish your Health Savings Account.

All Health Savings Account deductions are taken as Section 125-PreTax.

Please consult with your tax advisor to determine the correct amount allowed by the IRS to be contributed to your Health Savings Account. There is a maximum amount set by the IRS.

Name _____

I choose to have the sum of _____ deducted per pay for 20 pays into a Health Savings Account in my name at First Financial Bank.

I am entitled to Medicare and I choose for either \$1,000 for family coverage or \$500 for single coverage to be applied to my contribution of the premium. Yes____ No____

Account Number _____

**If I have elected the Health Savings Account benefit, I certify that I have met all the Health Savings Account eligibility requirements, which have been separately disclosed to me, and that I will notify my employer immediately in writing if I cease to meet any of the conditions for Health Savings Account eligibility during any months of the plan year. I also certify that I will use the Health Savings Account according to IRS guidelines. If this is not done, I will forfeit the employer contribution.

Signature _____

Date_____