2024 HEALTH SAVINGS ACCOUNT (HSA) CERTIFICATION FORM

UNIVERSITY OF ROCHESTER

Please fill out this form electronically and email the completed form to totalrewards@rochester.edu.

NAME: _____ _____ _____
LAST FIRST M.I.

EMPLOYEE ID NUMBER (*required*): _____

DAYTIME PHONE NUMBER: (____) ____ - _____ **DATE OF BIRTH:** ____ /____ /_____

Pay Cycle: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly

Changes to your home address, phone number, emergency contact(s), and/or self-identification data can be updated in HRMS by navigating to Main Menu > Self Service > Personal Information > Personal Information Summary. Please contact Ask-URHR at ask-urhr@rochester.edu or (585) 275-8747 for assistance.

HEALTH SAVINGS ACCOUNT (HSA)

Maximum HSA Contribution Amounts for 2024:

$4,150 is the maximum HSA contribution for those with single coverage.

$8,300 is the maximum HSA contribution for those with employee & spouse coverage, employee & children coverage, or family coverage.

If you are age 55 or older, you may contribute an additional $1,000 ($5,150 for single coverage and $9,300 for family coverage).

☐ I would like to begin contributing to an HSA.

Annual Health Savings Account Contribution: $_____

☐ I am currently contributing to an HSA at the University and would like to change my contribution amount.
Annual Health Savings Account Contribution: $_____

Please note, your new annual contribution amount is the total amount that will be deducted from your paychecks throughout the entire year (2024), including contributions that you have already made. For example, if you have already contributed $500, and would like to contribute an additional $750 during the remainder of the year, your new annual HSA contribution amount would be $1,250.

☐ I am currently contributing to an HSA and would like to stop any further contributions. I understand that it may take up to one full pay period to process this change, and that I may restart contributions at any time by completing a new HSA Certification form.

HSA ELIGIBILITY CRITERIA

Per the IRS Guidelines, individuals must meet ALL of the requirements below in order to contribute to an HSA.

- You must elect coverage under the University's YOUR HSA-Eligible Plan for 2024.
- 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 2024.
- 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 2024.
- 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 of the requirements above, to the best of my knowledge.

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

AUTHORIZE ELECTIONS AND CERTIFY DEPENDENT ELIGIBILITY

Please click within the box to scroll.

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/totalrewards or in hard copy at the University of Rochester Total Rewards 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 acknowledgment 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 2024 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

☐ I agree to the above terms and conditions.

SIGNATURE

☐ I acknowledge that providing my electronic approval is equivalent to signing the document and I understand that my electronic signature is binding.

FIRST & LAST NAME: _____

DATE: _____

This form is for 2024 HSA contributions only.