2027 HEALTH SAVINGS ACCOUNT ELECTION FORM

ACCOUNT HOLDER'S (EMPLOYEE'S) INFORMATION		
Last Name:	**First Name:**	**Middle:**
Employee ID #:	**Contact Phone #:**	**Department:**

Please check only *one* of the following options: Please note Contribution Limits: $4,500 EE only/$9,000 Family
Additional $1,000 Age 55 & over

New Deduction: ☐ **Change Amount:** ☐ **Cancel Deduction:** ☐ **Employer Only Funding:** ☐

For employee deductions, please make the following updates to my Health Savings Account:

Amount per pay period: $_____ [I understand any changes to my current elections will be effective the following pay period (except for new deductions; they are subject to plan eligibility requirements)]

By signing below: I hereby authorize Orange County Comptroller's Payroll Department to begin, change, or end my HSA employee contribution through Cigna. I understand that I must meet all of the following criteria in order to make contributions to my HSA:

- You must be covered under a high deductible health plan (HDHP)
- You must have no other health coverage that is not a high deductible health plan including TRICARE or TRICARE for Life
- You must not be covered by a general purpose Medical Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA), either yours or your spouse's (you can have a Limited Purpose Spending Account (LPFSA) and will have a separate debit card for this).
- You are not enrolled in Medicare
- You cannot receive VA medical benefits, unless for a service-related disability, within the 3 months prior to making a contribution
- You cannot be claimed as a dependent on someone else's tax return (Note: filing married/jointly is not the same as being claimed as a dependent)

I acknowledge that it is *my* sole responsibility to make sure the funds are used for eligible qualifying tax events and that I will be responsible for any taxes incurred if the expense is not eligible. I also understand that Orange County Government and Orange County Comptroller are not liable for any fees incurred by this account. I acknowledge that it is my responsibility (1) to determine whether I am eligible to make contributions to my HSA, and (2) to determine whether or not contributions to this HSA have exceeded the applicable maximum annual contribution limit. For current eligibility guidelines and contribution limits, please visit www.irs.gov under Health Savings Accounts.

**Note: Questions regarding the funds in this account must be directed to Cigna's HSA provider, 1-800-CIGNA24.

Signature: _____ **Date:** _____

PAYROLL USE ONLY	Processed by:	Audit:
HDHP coverage date:	Effective Date:	Paycheck effective date:

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