REFORMED BENEFITS ASSOCIATION
MASTER FLEXIBLE BENEFITS PLAN

ELECTION FORM

HEALTH SAVINGS ACCOUNT PRE-TAX CONTRIBUTIONS

Plan Year ending December 31, 20__

EMPLOYEE INFORMATION:

Name (print):	
Address:	
Position:	☐ Full-time ☐ Part-time
Type of health coverage: ☐ Self only ☐ Self + one or more dependents **You must be enrolled in the RBA's High Deductible Health Plan ("HDHP").**	

Reason for completing this Election Form:

- ☐ **Initial Election** (Election is effective the first of the month on or after the later of the date you become enrolled in the RBA's HDHP or the date of your election.)
- ☐ **Open Enrollment** (Election is effective January 1 of the next plan year.)
- ☐ **Election Change** (Election is effective on a prospective date in accordance with procedures established by the plan administrator.)

I elect to reduce my pay and have the pay reduction contributed on a pre-tax basis to my Health Savings Account ("HSA"). I elect to reduce my pay by $_____ for the plan year.

- I understand this pay reduction will be made in equal installments from my paychecks during the plan year (or the remaining portion of the plan year in the event of an initial election after the first day of the plan year).

- If this election form is being completed because I am making an election change after the first day of the plan year, any HSA pay reduction contributions I have already made up to this point in the plan year will be included in the amount indicated in the blank set forth

above and the balance will then be made in equal installments from my paychecks during the remaining portion of the plan year.

Acknowledgement

■ I have received and read the Summary Plan Description for the **Reformed Benefits Association Master Flexible Benefits Plan**.

■ I understand that I am only eligible to make pay reduction contributions to an HSA if I meet the following requirements:

- I am enrolled in an HDHP made available by the RBA;
- I am not covered by another health plan that is not an HDHP (including a medical flexible spending account that permits reimbursement for all types of medical claims); and
- I cannot be claimed as a dependent on another individual's tax return.

■ I understand that once I make an election, it will remain in force (including for subsequent plan years) unless I make a change.

■ I understand that I may change my election at least monthly as of any prospective date based upon the procedures established by the plan administrator.

■ I understand that the amount of my pay reduction contributions to my HSA, combined with any contribution Employer may make on my behalf, may not exceed the dollar limit established by federal law. (For 2014, the maximum annual contribution to your HSA if you are enrolled in single/employee-only coverage under the HDHP is $3,300. If you are enrolled in two-person or family coverage under the HDHP, your maximum annual HSA contribution is $6,550. These amounts can be increased by $1,000 if you are at least age 55 by the end of 2014.)

_____ _____

Employee's Signature Date

This form is accepted and received by _____ [print name of Employer Representative].

_____ _____

Signature of Employer Representative Date

ADMINISTRATIVE USE ONLY:

☐	Initial Election	■ ■	Hire Date: _____ Eligible Participation Date: _____
☐	Current Participant	☐ ☐	Open Enrollment Date: _____ Election Change Date: _____
■ ■	Pay Date of 1st Deduction: _____ Deduction Amount: _____		