Certification of Health Savings Account (HSA) Eligibility

Human Resources
115 Medical Sciences Building
3640 Colonel Glenn Hwy.
Dayton, OH 45435-0001
Tel: (937) 775-2120 Fax: (937) 775-3040

Employee Information			
Last Name:	**First Name, Middle Initial:**	**University ID:**	
Date of Birth:	**Daytime Phone:**	**Department:**	**Plan Year:**

I understand that in order to be eligible to contribute or have Wright State University make contributions on to a health savings account (HSA) my behalf, I must meet **all** of the following HSA eligibility conditions ***(please initial by all that apply)***:

_____ **1.** I have ____ individual coverage or ____ family coverage under the group health plan sponsored by my employer, Wright State University. I understand this plan qualifies as a High Deductible Health Plan (HDHP), which under code §223(c)(2) of the Internal Revenue Code.

_____ **2.** I am **not** covered under a non-HDHP health plan maintained by the employer of my spouse or registered domestic partner. (eg. Tricare, PPO, HMO)

_____ **3.** If my spouse, registered domestic partner, or I have any health coverage other than my coverage under the HDHP with Wright State University, that coverage is either:

____ (a) **HDHP coverage**

____ (b) **permitted non-HDHP insurance or coverage:** *insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (i.e. homeowner or auto insurance), or similar liabilities as specified by the IRS; insurance for a specified disease or illness (i.e. cancer insurance); insurance that pays a fixed amount per day (or other period) of hospitalization (i.e. hospital indemnity insurance); or coverage for accidents, disability, dental care, vision care, or long-term care.*

_____ **4.** I **cannot** be claimed as the tax dependent of another person.

_____ **5.** I am **not** enrolled in Medicare benefits.
An employee is ineligible to have contributions (Employee and Employer) to a HSA upon Medicare enrollment.

_____ **6.** I am **not** covered under a health care flexible spending account (FSA) through Wright State University or through a spouse or registered domestic partner. I understand that if I was enrolled in a health care FSA, and wish to enroll in HDHP/HSA coverage for the following plan year, the FSA grace period does not apply to me, and I must incur and exhaust all FSA funds by December 15th of the current plan year. If I do not exhaust the entire health care FSA balance by December 15th, my HDHP/HSA election is void and null.

Employee Acknowledgement	
By signing this form and returning it to Human Resources, I certify that all of the statements above are true. I agree that I will notify Human Resources immediately if I cease to meet any of these conditions. I also understand that Wright State University will make contributions to an HSA on my behalf on the basis of my certification and that Wright State University's HSA contributions and my own HSA contributions (if any) are subject to certain aggregate limits under federal tax law.	
Applicant's Signature:	**Date:**