# HSA Salary Reduction Agreement

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Saving Account through your Cafeteria Plan. **Do Not Send Contributions With This Form.**

By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" as defined by I.R.S. Code and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

## Account Holder Information (Please Print)

Name: (First) _____ (MI) _____ (Last) _____

## HSA Contribution Election (This contribution will remain in effect until a new salary reduction agreement is submitted.)

I elect a MONTHLY contribution of $ _____ (Amount) to my HSA effective 1/1/2025 (Date)

Attention current MSA or HSA account holder with accounts at other financial institutions: Please remember that the total annual contributions to all accounts may not exceed federally mandated limits.

## HDHP Information

Beginning Coverage Date for HDHP: 1/1/2025

Check One: ☐ Single ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

## Adoption Agreement/Employee Signature

As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that the H.S.A. Authority is facilitating but not initiating the contribution.

This application is for the establishment of my individually owned Health Saving Account at the custodian displayed below. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Account Agreement, HSA Terms and Conditions Statement and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the bottom of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder. I am currently, or will be upon the date of my first contribution, an eligible individual as described in the Custodial Account Agreement. I understand that maintaining my eligibility is my responsibility and that the custodian will assume that all contributions are made while I am eligible to do so. I am currently, or will be upon the date of my first contribution, covered by a High Deductible Health Plan that meets the qualifications detailed in the Custodial Account Agreement.

Signature of Account Holder _____ Date: _____

## Employer Signature

The employee's election of the Health Savings Account Contribution is acceptable as of the date shown below:

Authorized Signature: Amanda D. Vollman _____ Date: 1/1/2025

## Custodian

Warrick County School Corporation

## Plan Service Provider

U.M.B. Bank