HSA CONTINUED ENROLLMENT

ACCOUNT HOLDER INFORMATION	
First Name:	Last Name:
Date of birth:	
Spouses First Name (if applicable)	Last Name:
Date of birth:	
Address:	City, State and Zip:
High Deductible Health Plan Effective Date:	Single Plan ☐ Family Plan ☐

AUTHORIZATION AND CERTIFICATION

By receiving district contributions to an HSA, you understand and agree to the following:

- You are covered by a qualified high deductible health plan.
- You are not covered by any other non-qualified health coverage, including Medicare.
- If applicable, your spouse is not covered by any other non-qualified health coverage, including Medicare.
- You are not claimed as a dependent on another individual's tax return.
- If any above conditions change, you will notify the district within five (5) business days.

Print Name _____ Signature _____ Date _____

VERIFICATION AND RESPONSIBILITY

I assume complete responsibility for:

- Determining that I, or if applicable, my spouse is eligible for a HSA each year that I or the district make any contributions.
- Ensuring that all contributions that I make are within the limits set forth by the tax laws.
- The tax consequences of any contributions and distributions.

Print Name _____ Signature _____ Date _____