HSA Change of Status Form

Section I - Employee Information

Employer Name:				
Employee Name:		Social Security #:		
Check if new address ☐	Address:	City:	State:	Zip:
Check if new email address ☐	Email Address:			

Section II - Reason for HSA Change

- ☐ Single to Family
- ☐ Family to Single
- ☐ Other *(please add detailed notes in this section)*
- ☐ Termination Date/Benefit End Date *(i.e. termination of employment, changing from HDHP to PPO, enrolling in Medicare).*

Additional Comments:

Effective Date of the Change_____

Any changes noted above will generally change the IRS maximum that may be contributed in the calendar year. Please encourage HSA owners to contact us whenever there is a change so that we may discuss the rules.

Section III – Changes to Additional Benefits

If there are changes to plans other than the Health Savings Account (HSA), we need additional information.

Plan Name	Benefit End Date	**Current** Payroll Deduction Per Pay Period	**Revised** Payroll Deduction Per Pay Period	Date of Revised Deduction
FSA Health Care		$	$	
FSA Dependent Care		$	$	
Parking / Mass Transit		$	$	
HRA		N/A	N/A	N/A

Section IV - Employer Verification

Date _____ **Signature of Employer**_____

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