CITY OF Salem AT YOUR SERVICE

Open Enrollment Health Savings Account (HSA) Enrollment Form 2026

Employee Name

Address City State Zip

Email for BOA administrator system Phone Number

❑ New Enrollment ❑ Renewal Enrollment
❑ Contribution Change

HSA ACCOUNT

To be eligible to receive or contribute HSA contributions, you must meet the following IRS requirements:

- **You must be enrolled in an HSA-qualifying High Deductible Health Plan (i.e. the City of Salem HDHP medical plan)**
- **You cannot be covered by any other health plan (i.e. a spouse's non HDHP plan, traditional health FSA, or HRA)**
- **You cannot be covered by Medicare, Medicaid, or military health benefits**
- **You cannot be claimed as a dependent on another individual's tax return**

AGREEMENT FOR HEATH SAVINGS ACCOUNT & AUTHORIZATION

Benefit	Contribution Per Paycheck 24 paychecks in a full calendar year	# paychecks Remaining yr	Contribution per Plan Year
☐ I have waived coverage on the City of Salem health plan and elect the HSA for my Opt-Out Incentive. My other insurance is an HDHP medical plan.	$112.50 ($225 per month) Pro-rated based on FTE for part-time	x 24 =	$_____
☐ I am enrolled in the City of Salem HDHP, and I am eligible to receive City contributions to the HSA.	☐ Employee Only $70.83 ($141.67 per month) Pro-rated based on FTE for part-time OR ☐ Employee + Dependents $141.67 ($283.34 per month) Pro-rated based on FTE for part-time	x 24 =	**A.** ☐ Employee Only $_____ OR ☐ Employee + Dependents $_____
☐ I am enrolled in an HDHP medical plan, and I elect to have the following amount deducted pre-tax from my paycheck.	$ _____ Per paycheck	x 24 =	**B.** $ _____ Per year
The 2026 combined annual **A.**) Employer, and **B.**) Employee contribution, cannot exceed: • $4,400 if enrolled in employee only HDHP coverage; or • $8,750 if enrolled in employee plus dependents HDHP coverage. If you have attained age 55, you may contribute an additional $1,000 per year.		**A + B =**	$ _____ Per year

- I authorize the City of Salem to deduct pre-tax payroll contributions to fund my Health Savings Account as specified above.
- I understand that if my employment is terminated prior to the end of the Plan Year, the City of Salem will no longer absorb the administrative costs associated with the account, at which time the administrative fees will be deducted from my HSA.
- I hereby certify the above information to be correct and true to the best of my knowledge. I understand that the above deductions may correspondingly reduce my future Social Security benefits.
- My signature on this form certifies that I assume responsibility for determining that I am eligible for HSA contributions, for ensuring contributions to my HSA do not exceed the annual limits set forth by tax law, for ensuring my HSA is used only for qualified health care expenses, and I am responsible for any tax consequences due to excess contributions and/or ineligible distributions.
- Contribution changes can be completed at any time during the calendar year. Contributions are deducted evenly during the year, but a lump sum or specific number of paychecks to meet the annual maximum contribution can be selected. The maximum annual contribution can be met on a final paycheck of the year provided the employee will remain enrolled in an HDHP medical plan for the remainder of the calendar year.

Employee Signature: _____ **Date:** _____

Employer Use Only

Employee hire date (New enrollment only): _____
Employee effective date of coverage: _____
Verified contribution amount: ☐ Verify age 55+ (if applicable): ☐
Enrollment Reason: HDHP ☐ or Health Insurance Opt-out (HDHP other insurance) ☐
Division/BU: _____
HSA Tracking List: ☐ Oracle B050: ☐ Oracle Entry date: _____
New enrollment only: BOA website: ☐
BOA Bank Acct# in Pay Method & B050: ☐

HR Representative : _____ **Date:** _____

Employee #: _____
Employee first contribution date: _____
# of pay-periods remaining for the year: _____
FTE: Full-time ☐ or Part-time ☐ FTE _____
Employer Per Paycheck $ _____ Per Month $ _____
Employee Per Paycheck $ _____ Per Month $ _____