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HEALTH SAVINGS ACCOUNT (HSA) ENROLLMENT FORM SEPTEMBER 1, 2018 - DECEMBER 31, 2018

EMPLOYEE INFORMATION			
Name (Last, First):			Employee ID:
Mailing Address:			SSN#:
City:	State:	Zip Code:	Date of Birth:
E-mail address:		Phone (Daytime / Cell):	
Job Title:			Date of Hire:
Form of Identification: <input type="checkbox"/> Driver's License <input type="checkbox"/> State ID <input type="checkbox"/> Passport ID			
License / ID #:			
Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Resident Alien <input type="checkbox"/> Non-Resident Alien			
If not a U.S. citizen, enter country of residence:			

HSA ELECTION INFORMATION		
Per Pay Period:	Number of Pay Periods:	Annual Election:
\$		\$
2018 HSA ELECTION MAXIMUMS <ul style="list-style-type: none"> • HDHP Single Coverage - \$3,450 • HDHP Family Coverage - \$6,900 • Additional "catch-up" allowed for those 55 years of age or older - \$1,000 		

AUTHORIZATION AND ACKNOWLEDGEMENT	
<p>The annual maximum is the applicable statutory maximum for my High-Deductible Health Plan (HDHP) coverage type (i.e., single or family). The IRS may adjust this amount each year. Contributions are prorated based on the number of pay periods you will be covered under an HDHP. An exception to this rule allows participants with an HSA who are covered on December 1 to contribute the entire amount for the year. Your HSA contribution election can be changed prospectively, for any reason in accordance with the administrative provisions set forth by Human Resources.</p> <p>By electing HSA benefits, I am certifying that I meet the requirements under Internal Revenue Code § 223 to be eligible to contribute to an HSA. I understand that:</p> <ul style="list-style-type: none"> • I must be covered by an IRS qualified HDHP to contribute to an HSA. • I may not be claimed as a dependent on another individual's income tax return. • I may not be covered by other medical coverage, including Medicare or my spouse's Medical Flexible Spending Account. • HSA benefits cannot be elected in addition to a Medical Flexible Spending Account reimbursements unless a Limited Purpose Medical Flexible Spending Account is available. • For more information about HSA eligibility requirements, see IRS Publication 969. <p>Please return this form to your employer.</p>	
Employee Signature:	Date:

ASA College Human Resources Office

Received Date

HR Assistant Name and Title

HR Assistant Signature

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