Cornell University | Benefit Services & Administration

Health Savings Account Plan

an Endowed Program through Aetna

Enrollment Form

❒ New enrollment ❒ Change of enrollment

Employee Name (last, first, middle initial)			Social Security Number / /
Sex ( ) M ( ) F	Date of Birth / /		Employment Date / /
Home Address ______ City	State		Zip
Job Title	Department Name		Campus Address

I understand and acknowledge that my applicable dependent(s) and I are only eligible to enroll in Cornell University's Health Savings Account (HSA) Plan if I/we have met ALL the below listed requirements:

1. Covered only by an HSA-compatible high deductible health plan.
2. Not covered by any other health plan that is not an HSA-compatible high deductible health plan (including spousal coverage).
3. Not enrolled in Medicare (parts A, B, C, and D).
4. Not participating and/or have an account balance in a Cornell Medical Care Flexible Spending Account (FSA) (or have a spouse who participates in a general-purpose FSA) at the same time.
5. Not claimed as a dependent on another person's taxes (in the case of a dependent, such dependent must be claimed as a dependent on your taxes in order to qualify for use of your HSA funds).

Please select the coverage level you would like to enroll in below:

Effective date: / /	Coverage: ( ) Individual ( ) Individual + Child(ren)	( ) Individual + Spouse/Domestic Partner ( ) Individual + Spouse/Domestic Partner + Child(ren)

If you wish to cover your spouse or domestic partner, please check spouse ❒ or domestic partner ❒ and complete the following:

Name of Spouse or Domestic Partner (last, first, middle initial)		Spouse/Domestic Partner Social Security Number / /
Date of Marriage/Partnership / /	Spouse/Domestic Partner Date of Birth / /	Name of Spouse/Domestic Partner Employer
Sex ( ) M ( ) F	If employed by Cornell, name of department:	
	Name of Spouse/Domestic Partner employer:	

If you wish to cover your eligible dependent child(ren) or your domestic partner's child(ren), complete the following:

Name(s) of child(ren) (last, first, mi)	Date of Birth (mo/day/yr)	Male/Female	Relationship to you:	Social Security Number:

I also recognize that my spouse/domestic partner and I are only eligible for dual HSA eligibility (reduced individual + spouse/domestic partner + child(ren) health premium) **if I/we meet all the following requirements:**

1. We are both endowed employees.
2. We are both eligible for participation in the endowed health care plan.
3. I have dependent children covered by the plan.

If you are eligible for dual eligibility, please check here ( ) and have your spouse/domestic partner sign below:

Endowed Spouse/Domestic Partner ________________________ Signature Date ______________

Please complete both sides of this form and return to:
HR Services and Transitions Center, 395 Pine Tree Road, East Hill Office Building, Suite 130, Ithaca, New York 14850

Health Savings Account

Section A ***(complete this section if you are under age 55)***
I elect to contribute: (must enter amount even if zero)
This amount will be divided by 24 or 26 pay periods based on your pay cycle or the number of pay periods remaining in the calendar year (if enrolling anytime other than January 1).

❒ Single (maximum $3,850-$1,000 employer contribution=$2,850) $________.____
❒ Family (maximum $7,750-$1,000 employer contribution=$6,750) $________.____

Note: The maximum you can contribute is $3,850 (individual) or $7,750 (family) including the Cornell contribution ($1000) for 2023.

Section B "Catch Up" provision ***(complete this section if you are or will reach age 55 during the 2023 calendar year)***

I elect to contribute: (must enter amount even if zero)
This amount will be divided by 24 or 26 pay periods based on your pay cycle or the number of pay periods remaining in the calendar year (if enrolling anytime other than January 1).

❒ Single (maximum $3,850 − $1,000 employer contribution + $1,000 "catch up" = $3,850) $________.____
❒ Family (maximum $7,750 − $1,000 employer contribution + $1,000 "catch up" =$7,750) $________.____

Note: Employees turning age 55 during 2023 should enroll in the "catch up" provision even if you are not electing to contribute an additional $1,000. A spouse or domestic partner can also enroll in the "catch up" provision by contacting PayFlex to set up an unaffiliated account.

Note: The IRS regulations require you to remain covered under the HSA plan for at least 12 months after the last day of the plan year in which you enrolled in the HSA plan (if you have submitted a full year's maximum in less than a full year). Otherwise, any contributions made to the HSA for the months before the month you enrolled in the plan will be included in your gross income and subject to an additional tax of 10%.

I understand and agree that if I or any of my applicable dependents become ineligible for this HSA, then I must promptly notify Cornell University by contacting HR Services and Transitions Center within 60 days of becoming ineligible.

Note: Please refer to the Aetna Health Savings Account (HSA) - Cornell University Division of Human Resources to determine the amounts you will be able to contribute to the HSA, based on when you are eligible and how long you remain eligible.

I hereby declare that the information I provided during my enrollment is correct, and that to the best of my knowledge and belief, I am eligible to establish an HSA as indicated in my application, under the terms of Cornell University's health care program for endowed employees. I authorize and understand that my elected HSA contributions will be divided by 24 or 26 pay periods based on my pay cycle or if enrolling anytime other than January 1, the number of pay periods remaining in the calendar year.

I understand that employees who falsely certify their eligibility for an HSA may be subject to tax penalties and/ or disciplinary action.

Subject to acceptance of this application by PayFlex, I appoint PayFlex Systems USA, Inc. as my HSA custodian. I have received, read, and agree to the terms and conditions of the Aetna HSA Custodial Agreement and other disclosures contained in this Aetna Health Savings Account (HSA) Enrollment Package. In connection with my HSA, I request an HSA debit card be issued to me, and I agree to any additional terms and conditions established by the issuing bank in connection with that card. I understand that I will receive additional Program Terms, Conditions and Disclosures that will apply with respect to my debit card. I agree to comply with all laws and regulations governing HSAs and acknowledge that Aetna and PayFlex, its affiliates and contractors shall not be liable for any tax or other consequences related to my establishment, funding or use of the HSA.

Signature____**Date**__________________________

Employee Attestation for HSA Eligibility

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If you submit your HSA benefit election through Workday, you will receive an electronic version of this form in your Workday inbox. You must electronically sign the attestation in your inbox by clicking "I accept" to acknowledge the above eligibility requirements for your HSA enrollment to be processed.