Kansas Department of Health and Environment
Division of Health Care Finance

STATE EMPLOYEE HEALTH PLAN (SEHP)
HEALTH SAVINGS ACCOUNT (HSA)
ENROLLMENT AND CHANGE FORM

PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

For HR Use ONLY	
Employee ID #	
State Agency #	
Effective Date	

EMPLOYEE INFORMATION (EMPLOYEE MUST COMPLETE)

NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER

NEW ENROLLMENT — TYPE OF ACTION (CHECK ONE)

O Open Enrollment

O New Employee
Date of Hire: ____/____/____

O Other (Specify)
Date of Occurrence: ____/____/____

	Semi-Monthly Amount		Number of Pay Periods		Annual Amount
Health Savings Account (Employee Only Coverage)	_____	X	_____	=	_____
Health Savings Account (Employee and Dependent Coverage)	_____	X	_____	=	_____
Limited Scope Flexible Spending Account with Plan C ONLY	_____	X	_____	=	_____

CHANGE IN ENROLLMENT

SEMI-MONTHLY AMOUNT

O Health Savings Account (Employee Only Coverage) FROM: _____ TO _____

O Health Savings Account (Employee and Dependent Coverage) FROM: _____ TO _____

O Limited Scope FSA **FROM:** _____ **TO** _____

Date of Occurrence: _____

TYPE OF CHANGE (CHECK ONE)

O Name change from: _____

O Leave Without Pay – Estimated Return Date: _____/_____/_____

O Leave Under FMLA

O Return from Leave

O Change in Employment Status to O Benefits Eligible Position O Benefits Ineligible Position

O Termination

REQUESTS FOR THE FOLLOWING CHANGES MUST BE COMPLETED AND RECEIVED WITHIN 31 DAYS OF OCCURRENCE (WITH THE REQUIRED SUPPORTING DOCUMENTATION):

O Marriage of Employee O Childbirth/Adoption

O Final Divorce of Employee

O Spouse's Gain or Loss of Employment O Other (Specify): _____

AUTHORIZATION (CHECK ONE)

O I hereby authorize the salary reduction for the Health Savings Account by the amounts indicated above. I understand and agree to the terms of enrollment as listed on the reverse side of this form.

O I wish to discontinue my Health Savings Account salary reduction as indicated above.

EMPLOYEE AUTHORIZATION: By my signature below, I agree to the Terms and Conditions as listed on the reverse of this form. I also understand that I must provide supporting documentation regarding any qualifying event along with this enrollment form in order for my form to be processed.

Signed: _____ Date: _____
EMPLOYEE SIGNATURE – DO NOT PRINT

PERSONNEL OFFICER AUTHORIZATION: By my signature below, I understand that incomplete forms and forms submitted without required supporting documentation will be returned to me and must be returned to SEHP within 31 days of the qualifying event.

Personnel Officer Printed Name: _____

Personnel Officer Signature: _____

Telephone # (include ext.): _____ Date: _____

Rev: 10/12

AUTHORIZATION: TERMS AND CONDITIONS

HEALTH SAVINGS ACCOUNT

- You must be enrolled in one of the State Employee Health Plan (SEHP) - Qualified High Deductible Health Plans (QHDHPs) in order to enroll in a Health Savings Account (HSA).

- You are responsible for contacting US Bank in order to remit contributions to your HSA account. (Non State Employers only)

  The following three Vendors offer Plan C.
  Blue Cross and Blue Shield of Kansas
  Coventry/PHS
  UnitedHealthcare

  See our website www.kdheks.gov/hcf/sehp/HSA.htm for information on Plan C with HSA.

- Participation in the Health Savings Account means that your gross pay will be reduced by the amounts contributed to the accounts before federal, state, and FICA taxes are deducted.

- Expenses for which you are reimbursed cannot be deducted on your federal and state income tax returns.

- You cannot be claimed as a dependent on someone else's tax return.

- You are responsible for managing and directing the Health Savings Account and for documenting the use of the Health Savings Account funds in the event of an IRS audit.

- You understand that when you enroll in one of the QHDHP with Health Savings Account you will be ineligible to participate in the **Health Care** Flexible Spending Account (FSA).

- You understand that if you are currently enrolled in the Health Care FSA and should have any unused funds in your Health Care FSA at the end **of this plan year**, you agree to waive your right for reimbursement for Health Care FSA qualified expenses incurred during the grace period of January 1 through March 15th of the next calendar year.

- You have read and agree to the plan provisions in the State of Kansas Employee Benefits Guidebook