



**STATE EMPLOYEE HEALTH PLAN (SEHP)  
HEALTH SAVINGS ACCOUNT (HSA)  
ENROLLMENT AND CHANGE FORM**  
PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

<b>For HR Use ONLY</b>	Employee ID #	
	State Agency #	
	Effective Date	

**PLEASE NOTE: AN HSA BANK FORM MUST ALSO BE COMPLETED IN ORDER TO FINALIZE YOUR ENROLLMENT.**

**EMPLOYEE INFORMATION (EMPLOYEE MUST COMPLETE)**

NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER

**NEW ENROLLMENT TYPE OF ACTION (CHECK ONE)**

<input type="radio"/> Open Enrollment	<input type="radio"/> New Employee Date of Hire: ____/____/____	<input type="radio"/> Other (Specify) Date of Occurrence: ____/____/____
Health Savings Account (Employee Only Coverage)	Semi-Monthly Amount _____ X _____	Number of Pay Periods _____ = _____ Annual Amount
Health Savings Account (Employee and Dependent Coverage)	Semi-Monthly Amount _____ X _____	Number of Pay Periods _____ = _____ Annual Amount
Limited Scope Flexible Spending Account with Plan C ONLY	Semi-Monthly Amount _____ X _____	Number of Pay Periods _____ = _____ Annual Amount

**CHANGE IN ENROLLMENT**

**SEMI-MONTHLY AMOUNT**

Health Savings Account (Employee Only Coverage) FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Health Savings Account (Employee and Dependent Coverage) FROM: \_\_\_\_\_ TO: \_\_\_\_\_ Date of Occurrence: \_\_\_\_\_

Limited Scope FSA FROM: \_\_\_\_\_ TO: \_\_\_\_\_

**TYPE OF CHANGE (CHECK ONE)**

Name change from: \_\_\_\_\_

Leave Without Pay – Estimated Return Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Leave Under FMLA

Return from Leave

Change in Employment Status to  Benefits Eligible Position  Benefits Ineligible Position

Termination

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

Marriage of Employee  Childbirth/Adoption

Final Divorce of Employee  Other (Specify): \_\_\_\_\_

Spouse's Gain or Loss of Employment

**AUTHORIZATION (CHECK ONE)**

<input type="radio"/> 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.	<input type="radio"/> I wish to discontinue my Health Savings Account salary reduction as indicated above.
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**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: \_\_\_\_\_

## 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 the banking institution that corresponds with the SEHP Plan C vendor you select in order to establish your HSA account.

**The following three Vendors offer Plan C.**

Blue Cross and Blue Shield of Kansas  
Coventry/PHS  
UnitedHealthcare

**See our website [www.kdeheks.gov/hcf/sehp/HSA](http://www.kdeheks.gov/hcf/sehp/HSA) for information on Plan C with HSA, including the banks these vendors use for Health Savings Accounts.**

- 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.
- If the first salary reduction on your pay warrant does not match either the account or the amount on your Enrollment Form, it is your responsibility to contact your personnel office no later than 14 calendar days following the date the pay warrant was issued. If you fail to take this action, you waive your right to correct your election for the remainder of the current plan year.
- 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