Member Transaction Form

Fallon Health
Fallon Health & Life Assurance Co., Inc.

Fallon Select HSA-Qualified HMO

THE FOLLOWING SECTION IS TO BE FILLED OUT BY THE EMPLOYER:

Group number	Group name	Effective date: (MM/DD/YYYY)
55508-31	Town of Concord	

Please check off the reason you are filling out this form:

Adding coverage: ❑ New hire ❑ Annual open enrollment ❑ Other (Please explain in the Remarks section below.)

Ending coverage:
❑ Termination of employment ❑ Change to other insurance (Please provide the name of the other insurance in the Remarks section below.)
❑ Other (Please explain in the Remarks section below.)

Changes to existing coverage: (Please choose an option and explain in the Remarks section below.)
Change to: ❑ Individual plan ❑ Family plan ❑ COBRA ❑ Other
❑ Addition of a dependent (Please complete the dependent section of this form.) Date of qualifying event:[†] ____________
❑ Removal of a dependent ❑ Proof of qualifying event documentation included
❑ Change in name, address or other application information ❑ Other

Remarks:

This form is not complete without an authorized employer signature on page 2.

THE FOLLOWING SECTIONS ARE TO BE FILLED OUT BY THE EMPLOYEE (subscriber):

Please complete all applicable fields in this section.

Provider network: ❑ Direct Care* ❑ Select Care ❑ Fallon Preferred Care ❑ Steward Community Care*

Plan name: ____________

First name	Middle initial (MI)	Last name	Gender ❑ Male ❑ Female

Maiden name	Primary language	Birth date (MM/DD/YYYY)

Street address

City	State	ZIP code

Mailing address *(if different from street above)*

City	State	ZIP code

Would you be interested in receiving communications from Fallon via email? If so, please check the box and provide your email address: ❑	Home phone Mobile phone

Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date hired (MM/DD/YYYY)	Work phone

Race (please choose one) ❑ White ❑ Black ❑ Hispanic ❑ Asian/Pacific Islander ❑ American Indian/Alaskan Native ❑ Other

Work status (please choose one) ❑ Full time ❑ Part time ❑ Retired ❑ COBRA

Average # of hours worked weekly	Department #	Employee #

Does your spouse have health insurance from another source? ❑ Yes ❑ No

Please provide the name of your selected primary care provider (PCP). Is this your current PCP? ❑ Yes ❑ No

First name	MI	Last name

[†]Documentation required for qualifying event.

Benefits administrator: Please mail the white and yellow copies of this form to: Fallon Health Enrollment Operations, 10 Chestnut St., Worcester, MA 01608. The pink copy is for the employee. Or email form to: enrollmentrequests@fallonhealth.org. Or fax form to: 1-508-831-1136.

DEPENDENT SECTION:

In this section, please list all dependents covered under this plan. If you need more room, please use an additional Member Transaction Form.

Dependent 1: First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you | Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary language | Race | Birth date (MM/DD/YYYY)

Street address (if different from subscriber's)

Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No

First name MI Last name

Dependent 2: First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you | Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary language | Race | Birth date (MM/DD/YYYY)

Street address (if different from subscriber's)

Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No

First name MI Last name

Dependent 3: First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you | Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary language | Race | Birth date (MM/DD/YYYY)

Street address (if different from subscriber's)

Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No

First name MI Last name

Dependent 4: First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you | Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary language | Race | Birth date (MM/DD/YYYY)

Street address (if different from subscriber's)

Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No

First name MI Last name

Dependent 5: First name MI Last name (include maiden name if applicable) Gender ❑ Male ❑ Female

Relation to you | Social Security number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary language | Race | Birth date (MM/DD/YYYY)

Street address (if different from subscriber's)

Please provide the name of this dependent's primary care provider (PCP). Is this the dependent's current PCP? ❑ Yes ❑ No

First name MI Last name

I understand that my signature below means that I have read and I understand the contents of this form, and that I agree to the terms and conditions located on the back of this form.

X ______________________________ ______________________
Employee signature *(REQUIRED)* Print name here Date

X ______________________________ ______________________
Employer signature *(REQUIRED)* Print name here Date

Group name (please print) ______________________________

* Direct Care and Steward Community Care provide access to networks that are smaller than the Select Care network. In these plans, members have access to network benefits only from the providers in their respective network. Please consult the respective provider directory—paper copies can be requested by calling our Customer Service Department at 1-800-868-5200—or visit the provider search tool at fallonhealth.org to determine which providers are included in Direct Care and Steward Community Care.

**Required for tax purposes

Town of Concord
HSA Payroll Deduction Form
Plan Year: June 1, 2018 – May 31, 2019

Please complete and return form to:
Human Resources Department
Email: hr@concordma.gov Fax: (978)318-3024

Employee Name: ____

Desired Effective Date of Payroll Deduction: _____/_____/_____

Please note: This completed form must be received by Human Resources at least 2 weeks prior to the desired effective date for timely processing. Thank you!

Employee Contribution Election:

Payroll Deduction Amount	X # of Pay Periods (1-24)*	= Total HSA Election
$		$

** Deductions are taken in the first 2 pay dates of each month, with a maximum of 2 deductions per month (i.e., no deductions when there is a 3rd paycheck in a month).*

_________________________________ _____/_____/_____
Employee Signature **Date**

Important Notes about Contribution and Deduction Elections

- This HSA deduction election is only valid during Plan Year 6/1/18 – 5/31/19.
- You may change your deduction election during the Plan Year by submitting new election form(s).
- To be entitled to the full IRS maximum contribution, you must be HSA-eligible for the entire calendar year in which, or after, eligibility begins. *See page 2 of this form for more information about eligibility for the full contribution limits.*
- Use caution and consider IRS proration rules if you wish to make accelerated contributions early in the plan and/or calendar year, rather than spreading them out over 12 months. *See page 2 of this form for more information about prorated contribution limits.*
- To reduce excess contributions in the event your HSA-eligibility ends before a calendar year is completed, limit your biweekly payroll deduction to no more than the prorated employee contribution limit: Self-only = $102.08; Family = $202.08 (55+ catch-up, add $41.66)
- IRS contribution limits are based on the calendar year, not plan year.
- Excess contributions are subject to IRS penalties and taxes, if not addressed via your tax return.
- If you are covered under an HSA-Qualified health insurance plan for only a portion of a month, your HSA-eligibility begins the 1st day of following month.
- Please refer to IRS Publication 969 and Form 8889 Instructions for more information.

Administrative fees associated with maintaining your HSA account are paid by Town while you are enrolled in a Town-provided HSA-Qualified plan. If you stop coverage under a Town HSA-Q plan, you will be responsible for any fees associated with maintaining the HSA account.

For HR Use: Finance ____ HRIS ____ Form date: 4/13/2018

Helpful Health Savings Account (HSA) Information
(Please complete page 1 of this form)

HSA-Eligibility Information

Your Health Savings account is your financial asset even if you change employers or health plans. To open and make contributions to a Health Savings Account, you must meet three criteria:

1) You must be covered by a qualified high-deductible health insurance plan (HSA-Q).
2) You cannot be covered by another health plan, including Medicare or a Health Care Flexible Spending Account. (You may be covered by a Limited Purpose Flexible Spending Account or Limited Use/Purpose Health Reimbursement Arrangement.)
3) You cannot be claimed as a dependent on another individual's tax return.

You are considered **"HSA-eligible"** during each full calendar month that you meet the above criteria.

HSA Contribution Limits & Proration for Partial Years of HSA-Eligibility

Once you begin HSA-eligibility (whether through Concord or elsewhere), you are subject to an IRS "Testing Period" to determine whether you are eligible for the entire calendar year contribution amount, or a prorated limit. Contributions made over the limits are considered "excess" and are subject to taxes and penalties.

FULL HSA CONTRIBUTION LIMITS

If you are HSA-eligible on December 1, AND you are HSA-eligible for that entire calendar year OR remain eligible for the entire calendar year thereafter, you are eligible for the entire annual maximum HSA contribution, as follows:

Calendar Year 2018 – Full Contribution Limits			
HSA-Q Coverage Type:	Total Annual Contribution* *(employer + employee)*	Concord Contribution *(counts toward annual max)*	Max Employee Contribution in CY2018
Individual	$3,450	$1,000	$2,450*
Family	$6,850	$2,000	$4,850*

*Catch-up contribution (age 55+): additional $1,000/year

- Employees who begin HSA-eligibility in 2018 must remain HSA-eligible through 12/31/2019 in order to contribute the full amount in 2018 and/or 2019.
- Employees who begin HSA-eligibility in 2019 must remain HSA-eligible through 12/31/2020 in order to contribute the full amount in 2019 and/or 2020.

PRORATED HSA CONTRIBUTION LIMITS

If you are not eligible for the full contribution limits described above, your annual contribution limit is prorated based on the number of full calendar months you were eligible. Your annual limit is the monthly amount shown below times the number of months of HSA-eligibility:

Calendar Year 2018 – Prorated Contribution Limit		
HSA-Q Coverage Type:	Total Annual Contribution* *(employer + employee)*	Contribution per Month of HSA-Eligibility* *(employer + employee)*
Individual	$3,450	$287.50
Family	$6,850	$570.83

*Catch-up contribution (age 55+): additional $1,000/year; $83.33/month

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Questions? For further information or to review eligibility, please contact:
Health Equity Member Services at 866-346-5800 or www.healthequity.com/hsalearn