The Harvard Pilgrim HMO

PO BOX 9185 • QUINCY, MA 02269
1-888-333-HPHC
www.harvardpilgrim.org

Harvard Pilgrim HSA-Qualified HMO

REASON FOR SUBMISSION (PLEASE CHECK ALL THAT APPLY)

☐ **ENROLLMENT**
- ☐ NEW HIRE ☐ COBRA
- ☐ ANNUAL OPEN ENROLLMENT
- ☐ LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS)
- ☐ P/T TO F/T DATE _____

☐ **CHANGE**
- ☐ CHANGE COVERAGE TYPE
- ☐ ADD DEPENDENT LISTED BELOW
- ☐ TERMINATE DEPENDENT LISTED BELOW
- ☐ NAME/ADDRESS CHANGE
- ☐ LOSS OF INSURANCE DATE _____ (ATTACH DOCUMENTS)
- ☐ MARRIAGE DATE _____
- ☐ NEWBORN DATE _____

☐ **TERMINATION**
- ☐ LEFT EMPLOYMENT ☐ NO LONGER ELIGIBLE
- ☐ VOLUNTARY CANCELLATION ☐ DECEASED DATE _____
- ☐ MOVED FROM SERVICE AREA

TO BE COMPLETED BY HPHC ONLY.	GROUP / COMPANY NAME	DATE OF HIRE	GROUP #/DIVISION	EFFECTIVE DATE
H P	Town of Concord		0 7 4 7 4 8 — 0 0 1 3	

EMPLOYEE NAME

FIRST **MIDDLE** **LAST**

HOME ADDRESS

APT. NO. STREET PO BOX

CITY STATE ZIP COUNTY

TELEPHONE (HOME) ( )

TELEPHONE (WORK) ( )

TYPE OF COVERAGE
☐ INDIVIDUAL ☐ 2-PERSON (ONLY WHERE OFFERED)
☐ FAMILY ☐ OTHER _____

PLEASE USE THE CODES LISTED BELOW TO COMPLETE DEPENDENT RELATION BLOCK

02—SPOUSE/CIV UN **03**—CHILD UNDER 19, CHILD TAX DEP 19-25 (MA ONLY), CHILD 19-25 TAX DEP/2 YR EXTN (MA ONLY), CHILD UP TO 26 (NH ONLY) **04**—STEPCHILD UNDER 19 **05***—FULL-TIME STUDENT 19 AND OVER **06**—HANDICAPPED (VERIF REQ **07**—EX-SPOUSE

IT IS VERY IMPORTANT THAT EACH MEMBER SELECT A PRIMARY CARE PHYSICIAN.
AS A PLAN MEMBER YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN (PCP). IF YOU DO NOT HAVE A PCP, NON-EMERGENCY AND MOST SPECIALTY CARE MAY NOT BE COVERED.

FIRST MI LAST (IF NOT SAME AS EMPLOYEE)	LANGUAGE CODE	DATE OF BIRTH MO DAY YR	SEX	RELATION CODE	SOCIAL SECURITY NUMBER	SELECT A PRIMARY CARE PHYSICIAN AND TOWN FOR EACH MEMBER	ARE YOU A REGULAR PATIENT OF THIS DOCTOR?	PCP#
EMPLOYEE		- -	M F	01	- -		Y N	
SPOUSE		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	
DEPENDENT		- -	M F		- -		Y N	

LANGUAGE CODES (OPTIONAL)

WHAT LANGUAGE DO YOU SPEAK MOST OFTEN? PLEASE LIST THE APPROPRIATE CODE AFTER EACH MEMBER'S NAME. THIS INFORMATION WILL HELP US WORK TOWARD BEST MEETING YOUR NEEDS.

AS American Sign Language · CA Cantonese · CV Cape Verdean · EN English · FR French · HA Haitian · HM Hmong · IT Italian · KH Khmer · LO Laotian · MN Mandarin · PT Portuguese · RU Russian · SP Spanish · VI Vietnamese · OTHER ☐ _____ Specify

*** IF YOU HAVE LISTED A FULL-TIME STUDENT(S) AGE 19 AND OVER, BUT UNDER THE MAXIMUM STUDENT AGE, PLEASE SUPPLY THE FOLLOWING INFORMATION:**

STUDENT(S) NAME **NAME OF SCHOOL(S)** **STATE**

_____

_____

_____

THIS INFORMATION MAY BE USED TO VERIFY ELIGIBILITY

HAVE YOU EVER BEEN A MEMBER OF HPHC, HPHC OF NE, OR HPHC INSURANCE COMPANY? ☐ YES ☐ NO

IF YOU WOULD LIKE TO RECEIVE A MENU OF ELECTRONIC WAYS TO INTERACT WITH US, LIST YOUR E-MAIL ADDRESS HERE.

E-MAIL ADDRESS: _____ (OPTIONAL)

YOUR E-MAIL ADDRESS WILL BE STORED IN A PROTECTED DATABASE AND WILL REMAIN CONFIDENTIAL.

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY THE PLAN. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN A SEPARATE DOCUMENT. FOR AN EXPLANATION OF HOW HARVARD PILGRIM MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES PROVIDED TO YOU BY HARVARD PILGRIM IN YOUR ENROLLMENT KIT.
MAINE MEMBERS: PLEASE NOTE THAT THE SUBROGATION PROVISION APPLICABLE TO MAINE MEMBERS, OUTLINED IN A SEPARATE DOCUMENT, PERMITS SUBROGATION PAYMENTS ON A JUST AND EQUITABLE BASIS.
I UNDERSTAND THAT A COPY OF THIS FORM WILL BE GIVEN TO ME, OR MY AUTHORIZED REPRESENTATIVE, UPON REQUEST.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

THE EMPLOYEE AND THE EMPLOYER MUST SIGN AND DATE THIS FORM FOR ENROLLMENT.

_____ _____ _____ _____
EMPLOYEE SIGNATURE DATE EMPLOYER SIGNATURE DATE

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

HealthEquity
Building Health Savings

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.

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

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