Tufts HSA-Qualified HMO

TUFTS Health Plan

MEMBER ENROLLMENT FORM

FAILURE TO COMPLETE AREAS MARKED IN BLUE WILL CAUSE A DELAY IN ENROLLMENT.

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 9186 • Watertown, MA 02471-9186

EMPLOYER SECTION

Group/Company Name Town of Concord Group Number 54707-010

Office Location ____ Date of Hire ____ Effective Date of Coverage ____

Type of Enrollment: ❑ New Hire ❑ Open Enrollment ❑ COBRA ❑ New Group ❑ Qualifying Event (MUST specify) ____ Qualifying Event Date ____

MEMBER SECTION

PRODUCT (Select corresponding letter from the list on the front page) ____ Other ____

Last Name ____ First Name ____ Middle Initial ____ Primary Language ____

Employee Social Security Number (required) ____ - ____ - ____ Date of Birth (MM/DD/YYYY) ____ / ____ / ____ Gender: ❑ Male ❑ Female

Email Address ____ Home Telephone (____) ____ Work Telephone (____) ____

Mailing (Home) Address ____ City ____ State ____ ZIP ____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner Type of Coverage Requested: ❑ Individual ❑ Family ❑ Other ____

Primary Care Provider First Name ____ Last Name ____ PCP ID# ____ Are you an established patient of this PCP? ❑ Yes ❑ No

Members Enrolling (First name, include last name if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number	Choose a Primary Care Provider for each member (Include first and last name.)	Check if currently used for primary care	PCP ID #
❑ Spouse ❑ Domestic Partner			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	

Please check if you are using additional membership applications for additional dependent children. ❑

Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ❑ Yes ❑ Yes (Medicare) ❑ No

Name of Health Plan ____ Name of Plan Holder ____ Health Plan Number ____ Effective Date ____

Names of Family Members Covered ____ Is Spouse Employed? ❑ Yes ❑ No If Yes, Name and Address of Employer ____

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Member Services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature (required) ____ Date ____ Benefits Dept. Signature ____ Telephone ____ Date ____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.

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.

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