Cornell University
Division of Human Resources

Health Savings Account Plan an Endowed Program through Aetna Enrollment Form

❒New enrollment ❒Change of enrollment

Employee Name (last, first, middle initial)		Social Security Number / /
Sex ( ) M ( ) F	Date of Birth / /	Employment Date / /
Home Address ______ City State Zip		
Job Title	Department Name	Campus Address

You are eligible to enroll in the HSA Plan if you are:

1. Covered only by an HSA compatible high deductible health plan.
2. Not covered by any other health plan that is not an HSA compatible high deductible health plan.
3. Not eligible for Medicare (parts A, B, C, and D).
4. Not participating in a Cornell Medical Care Flexible Spending Account (FSA) at the same time.
5. Do not have an account balance in your 2018 Cornell Medical Care Flexible Spending Account (FSA) on 12/31/18.
6. Not claimed as a dependent on another person's taxes.

Please select the coverage level you would like to enroll in below:

Effective date: / /	Coverage: ( ) Individual ( ) Individual + Spouse/Domestic Partner ( ) Individual + Child(ren) ( ) Individual + Spouse/Domestic Partner + Child(ren)

If you wish to cover your spouse or domestic partner, please check spouse ❒ or domestic partner ❒ and complete the following:

Name of Spouse or Domestic Partner (last, first, middle initial)		Spouse/Domestic Partner Social Security Number / /
Date of Marriage/Partnership / /	Spouse/Domestic Partner Date of Birth / /	Name of Spouse/Domestic Partner Employer
Sex ( ) M ( ) F	If employed by Cornell, name of department:	
	Name of Spouse/Domestic Partner employer:	

If you wish to cover your eligible dependent child(ren) or your domestic partner's child(ren), complete the following:

Name(s) of child(ren) (last, first, mi)	Date of Birth (mo/day/yr)	Male/Female	Relationship to you:	Social Security Number:

You are eligible for dual eligibility (reduced individual + spouse/domestic partner + child(ren) health premium) **if you meet all the following requirements:**

1. You and your spouse/domestic partner are both endowed employees.
2. You and your spouse/domestic partner are both eligible for participation in the endowed health care plan.
3. You have dependent children covered by the plan.

If you are eligible for dual eligibility, please check here ( ) and have your spouse/domestic partner sign below:

Endowed Spouse/Domestic Partner ______________________Signature Date____________

Please complete both sides of this form and return to:
HR Services and Transition Center, 395 Pine Tree Road, East Hill Office Building, Suite 110, Ithaca, New York 14850

Health Savings Account

Section A ***(complete this section if you are under age 55)***

I elect to contribute: (must enter amount even if zero)

This amount will be divided by 24 or 26 pay periods based on your pay cycle or the number of pay periods remaining in the calendar year (if enrolling anytime other than January 1).

❒ Single (maximum $3,500-$1,000 employer contribution=$2,500) $________.____

❒ Family (maximum $7,000-$1,000 employer contribution=$6,000) $________.____

Note: The maximum you can contribute is $3500 (individual) or $7000 (family) including the Cornell contribution ($1000) for 2019.

Section B "Catch Up" provision ***(complete this section if you are or will reach age 55 during the 2019 calendar year)***

I elect to contribute: (must enter amount even if zero)

This amount will be divided by 24 or 26 pay periods based on your pay cycle or the number of pay periods remaining in the calendar year (if enrolling anytime other than January 1).

❒ Single (maximum $3,500 − $1,000 employer contribution + $1,000 "catch up" = $3,500) $________.____

❒ Family (maximum $7,000− $1,000 employer contribution + $1,000 "catch up" =$7,000) $________.____

Note: Employees turning age 55 during 2019 should enroll in the "catch up" provision even if you are not electing to contribute an additional $1,000. A spouse or domestic partner can also enroll in the "catch up" provision by contacting PayFlex to set up an unaffiliated account.

Note: The IRS regulations require you to remain covered under the HSA plan for at least 12 months after the last day of the plan year in which you enrolled in the HSA plan (if you have submitted a full years maximum in less than a full year). Otherwise, any contributions made to the HSA for the months before the month you enrolled in the plan will be included in your gross income and subject to an additional tax of 10%.

I hereby declare that the information provided is correct, and that to the best of my knowledge and belief, I am eligible for insurance under the terms of Cornell University's health care program for endowed employees. I hereby request the insurance thereunder to which I am entitled or to which I may become entitled. I authorize and understand that health insurance premiums will be retroactive to the eligibility date or qualifying event date. This means that double deductions will be taken from my paycheck if back premiums are owed. I also agree to review the imputed income information if I am covering a domestic partner at the following link: https://hr.cornell.edu/benefits-pay/benefits-enrollment/marriage-or-domestic-partnership.

I certify that I am eligible to establish an HSA and that the information I have provided in this enrollment form, including my social security number, is true and correct. Subject to acceptance of this application by PayFlex, I appoint PayFlex Systems USA, Inc. as my HSA custodian. I have received, read and agree to the terms and conditions of the Aetna HSA Custodial Agreement and other disclosures contained in this Aetna Health Savings Account (HSA) Enrollment Package. In connection with my HSA I request an HSA debit card be issued to me, and I agree to any additional terms and conditions established by the issuing bank in connection with that card. I understand that I will receive additional Program Terms, Conditions and Disclosures that will apply with respect to my debit card. I agree to comply with all laws and regulations governing HSAs and acknowledge that Aetna and PayFlex, its affiliates and contractors shall not be liable for any tax or other consequences related to my establishment, funding or use of the HSA.

Signature____**Date**_____________________________