Checklist for
Health Savings Account ("HSA")

Person to Contact with Questions: ____________________

Telephone Number: (   ) ____________________

Email Address: ____________________

GENERAL PLAN INFORMATION

Group's Full Name: ____________________

Group's Address: ____________________

____

If above address is a post office box, street address: ____________________

____

Group's Telephone Number: (   ) ____________________

Internal Group Number or Billing Number (if any): ____________________

Employer Identification Number (EIN): ____________________

Plan Year (month to month): ____________________

Original Effective Date of Plan (month & year): ____________________

Date of this Restatement (month & year): ____________________

Type of Plan: Health Savings Account Under Code §223

Trustee: ____________________

____

Participating Employers: ____________________

____

Third Party Administrator: ____________________
Name, Address, Phone:

____

PURPOSE OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT

Specifically, partners in a partnership and employees who hold more than 2% of the shares in a subchapter S corporation should consult their tax professionals regarding the tax implications of participating in this plan, as well of as the tax implications of both employer and individual contributions to *health savings account*.
OPTIONAL – KEEP or REMOVE

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?
After you become a *participant* under the Plan, if your employment ends and you return to *active employment* within [_______________] **(months OR years)**, your participation will take effect on the first day you return to *active employment.*

If you had not satisfied your *waiting period* before your employment ended and you return to *active employment* within [_______________] **(months OR years)**, you will be given credit for the period of time previously credited toward satisfaction of your *waiting period* on the first day you return to *active employment*.
OPTIONAL – KEEP or REMOVE

When will I become a *participant* in the *Plan*?

	You may enroll in the *Plan* at any time after you have met the above eligibility requirements; **OR**
	You must enroll in the plan within [__________] days following the date of eligibility

	Participation will become effective on the [first day of the month following the] date you enroll in the *Plan;* **OR**
	Participation will become effective on the [first day of the month following the] date you are eligible provided you have enrolled for participation on a form satisfactory to the *Plan Administrator*; **OR**
	Other:

What if I do not enroll during my original eligibility period and later decide to enroll?
If you did not enroll during your original [_____]-day eligibility period, and have now decided to enroll, you may do so by making written application to the *Plan Administrator*.

Your participation will become effective at 12:01 A.M. on the:

	1st day following enrollment; **OR**
	1st day of the month following enrollment; **OR**
	Other:

You may enroll during the *Plan's* annual open enrollment period, which is the month of [____________________] in each *calendar year*.

BENEFITS

What are examples of qualified and non-*qualified medical expenses*?
Examples of non-*qualified medical expenses* include:

	Hormone therapy relative to gender identity disorders
	Sexual reassignment surgery, including all related expenses

FUNDING

It is recommended that partners in a partnership and employees who hold more than 2% of the shares in a subchapter S corporation should consult their tax professionals regarding the tax implications of participating in this plan, as well as the implications of both employer and individual contributions to *health savings account*.
OPTIONAL – KEEP or REMOVE

How is my *health savings account* funded?
The *Plan Sponsor* shall contribute to each *participant's* account employer contributions in the amount of

	$[__________] per pay period; **OR**
	$[__________] per pay period if the participant has elected individual coverage under the *high deductible health plan* and $[__________] per pay period if the *participant* has elected family coverage under the *high deductible health plan*

The *Plan* is intended not to discriminate in favor of highly compensated individuals as to the contributions of the *Plan Sponsor,* and is intended to comply in this respect with the requirements of the *Code.* If, in the judgment of the *Plan Administrator*, the operation of the *Plan* in any *calendar year* would result in such discrimination, then the *Plan Administrator* shall select and exclude employer contributions under the *Plan* to such highly compensated individuals who are *participants,* and/or reduce contributions under the *Plan* to the *health savings accounts* of highly compensated individuals who are *participants,* to the extent necessary to assure that, in the judgment of the *Plan Administrator,* the *Plan* does not discriminate.

The *Plan Administrator* will have the full authority to reduce the employer contributions who are members of prohibited groups under *Code § 125* to the extent necessary to prevent the *Plan* from discriminating in favor of such prohibited group(s).
THIS ENTIRE SECTION IS OPTIONAL – KEEP or REMOVE

	The *Plan Sponsor* will accelerate **part** of its contributions for the entire year to *participants* who have *incurred* during that *calendar year* qualified medical expenses exceeding the *Plan Sponsor's* cumulative contributions at that time.
	The *Plan Sponsor* will accelerate **all** of its contributions for the entire year to *participants* who have *incurred* during that *calendar year* qualified medical expenses exceeding the *Plan Sponsor's* cumulative contributions at that time.

These contributions will be available on an equal and uniform basis to all *participants* throughout the *calendar year*.
THIS ENTIRE SECTION IS OPTIONAL – KEEP or REMOVE

TERMINATION OF PARTICIPATION

Will my *participating employer* continue to make contributions?
Is coverage continued in the event of:

Yes	No	Item	For How Long
		Layoff	
		Total Disability	
		Leave of Absence which does not meet the requirements of FMLA Leave	

DEFINITIONS

"Dependent" means… *(please choose one)*

<table>
<tr><td></td><td>…any of the following individuals who reside in the employee's household and over half of whose support the employee provides:

<table>
<tr><td></td><td>Children of the participant</td><td></td><td>Stepchildren of the participant</td></tr>
<tr><td></td><td>Grandchildren of the participant</td><td></td><td>Parents of the participant</td></tr>
<tr><td></td><td>Siblings of the participant</td><td></td><td>Grandparents of the participant</td></tr>
</table></td></tr>
<tr><td></td><td>…any of the following individuals who reside in the employee's household [, who qualify as a dependent pursuant to Code § 152,] and over half of whose support the employee provides:

<table>
<tr><td></td><td>Children of the participant</td><td></td><td>Stepchildren of the participant</td></tr>
<tr><td></td><td>Grandchildren of the participant</td><td></td><td>Parents of the participant</td></tr>
<tr><td></td><td>Siblings of the participant</td><td></td><td>Grandparents of the participant</td></tr>
</table></td></tr>
</table>

Children whose parents are divorced, legally separated, separated under a written separation agreement, or whose parents have lived apart at all times during the last six months of the calendar year, will be considered a *dependent* so long as they receive over one-half of their support from their parents and are in the custody of one or both parents for more than one-half of the calendar year.
OPTIONAL – KEEP or REMOVE

"Employee"
Such person must be scheduled to work at least [__________] hours per week in order to be considered "full-time" or at least [__________] hours per week to be considered "part-time."

An *employee* is not a seasonal, temporary or leased *employee*, an independent contractor a sole proprietor, a partner in a partnership, or more than 2% shareholder in a subchapter S corporation.
OPTIONAL – KEEP or REMOVE