Family Savings Plan™
Enrollment and Attestation Form

*****Please submit to this completed form to your Human Resources Representative*****

PARTICIPANT INFORMATION			
1.	Employer Name:		
2.	Employee Name:	Birth Date:	Hire Date:
3.	I am a: ☐ Current employee ☐ New employee		
4.	If you are a current employee enrolled in your employer's medical plan, the following individuals are currently enrolled (skip this question if a new employee): ☐ Employee ☐ Employee + Spouse ☐ Employee + Dependent(s) ☐ Family		
5.	I am enrolling in the following tier of coverage in the Family Savings Plan: ☐ Employee ☐ Employee + Spouse ☐ Employee + Dependent(s) ☐ Family ☐ Spouse only ☐ Dependent(s) only ☐ Spouse + Dependent(s)		
6.	Social Security No:	Gender: ☐ M ☐ F	
7.	Date Eligible for Family Savings Plan:		
8.	Employee ID #:	☐ Full Time ☐ Part Time	
9.	Home Street Address:		
	City:	State:	Zip Code:
	Home Phone:	Work Phone:	Cell Phone:
	Email Address:		
10.	We may email you to keep you updated on the status of your Family Savings Plan enrollment, claims and reimbursements. ☐ Do not email me		
SPOUSE INFORMATION			
11.	Spouse Name:	Birth Date:	Gender: ☐ M ☐ F
12.	Social Security No:	Spouse's Employer:	

**Form continued on next page.*

DEPENDENT INFORMATION IF ENROLLING IN FAMILY SAVINGS PLAN				
1.	Name:	Birth Date:	Gender: ☐ M ☐ F	
	Social Security No:	Is dependent living at a different address? ☐ No ☐ Yes If yes, list below.		
	Address:	City:	State:	Zip Code:
2.	Name:	Birth Date:	Gender: ☐ M ☐ F	
	Social Security No:	Is dependent living at a different address? ☐ No ☐ Yes If yes, list below.		
	Address:	City:	State:	Zip Code:
3.	Name:	Birth Date:	Gender: ☐ M ☐ F	
	Social Security No:	Is dependent living at a different address? ☐ No ☐ Yes If yes, list below.		
	Address:	City:	State:	Zip Code:
4.	Name:	Birth Date:	Gender: ☐ M ☐ F	
	Social Security No:	Is dependent living at a different address? ☐ No ☐ Yes If yes, list below.		
	Address:	City:	State:	Zip Code:

PARTICIPANT AUTHORIZATION

I hereby authorize my employer to enroll me in the Family Savings Plan. I agree to comply with the terms and conditions of the plan. I understand that if the health premium contributions are deducted on an After-Tax Basis, this will result in all premium reimbursements being income tax free. However, if the contributions are on a Pre-Tax Basis, the premium reimbursements will be fully taxable. Deductible, copayments and coinsurance reimbursements will remain tax free. **I further understand that if any current contributions are made to a Health Savings Account (HSA) by my spouse or his/her employer, I am not eligible to participate in the Family Savings Plan offered through my employer.**

Employee Signature:	Date:

Attestation of Enrollment in the Family Savings Plan™

Employee Name: _____ Date: _____

This *Attestation of Enrollment in the Family Savings Plan* must be completed to be eligible for participation in the Family Savings Plan.

By signing below, I certify that:

1) My employer has offered me and my eligible dependents a group health plan that does not consist solely of "excepted benefits" under the Patient Protection and Affordable Care Act of 2010 ("PPACA");

2) I, and/or my spouse, and/or my eligible dependents are enrolled in a group health plan sponsored by another employer (such as my spouse's employer) that does not consist solely of "excepted benefits" under PPACA (such as limited-scope dental or vision coverage), nor does it consist solely of a "health reimbursement arrangement" (reimbursement of health care expenses up to a dollar limit).
3) I am waiving participation in my employer's medical plan for my covered Family Savings Plan enrollees as follows (please name all enrollees):

Name: _____ Name: _____
Name: _____ Name: _____
Name: _____ Name: _____
Name: _____ Name: _____

4) The other employer-sponsored plan coverage is **not**:
   - High Deductible Health Plan (HDHP) with **active** contributions to a health savings account (HSA)*
   - Medicare, Tricare, Medicaid
   - Individual plan purchased on or off the Health Insurance Exchange (also known as the Marketplace)
   - A stand-alone health reimbursement account (HRA), not paired with a medical plan
   - Short-term individual coverage
   - Limited Benefit Health Plan under IRS rules

*If HSA employer and employee contributions are not active or are discontinued, employees/spouses/dependents may be eligible for the Family Savings Plan.

By signing below, you are attesting that you meet the Family Savings Plan eligibility requirements described above.

Employee Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____
(only if eligible for the Family Savings Plan)

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EMPLOYER TO COMPLETE THIS SECTION		
1.	Current Plan Name:	
2.	Current Tier Level of Plan:	
3.	Department:	Active or Retiree (if Applicable):
4.	Current Monthly Employee Contribution:	
5.	Current Monthly Employer Contribution:	