

Qualification Questionnaire for Health Savings Account

EXCEPT AS SET FORTH IN THIS AGREEMENT, WE DO NOT MAKE ANY REPRESENTATIONS AND WARRANTIES WHETHER EXPRESS, STATUTORY OR IMPLIED. THIS QUESTIONNAIRE IS ATTACHED TO THE PAYFLEX CUSTODIAL AGREEMENT-2020.

Acceptance of Agreement

Your application/enrollment for an HSA forms part of this agreement and constitutes your acceptance of its terms. You will provide us any information we reasonably request to verify your identity. We may refuse to accept any application/enrolment for an HSA at our discretion; however, our acceptance of your application/enrollment constitutes our agreement to the terms in the document provided.

Please keep this agreement with your HSA records.

1. Are you covered by another health plan (spouse's employer plan, etc.)? YES NO

If you are dual covered and your other medical plan is also a high deductible plan, then answer NO above

If you are dual covered, and your other medical plan is not a high deductible plan, then answer YES above

2. Are you enrolled in MediCare or TriCare? YES NO

Once enrolled in Medicare or TriCare, IRS doesn't allow you to contribute to your HSA

3. Are you being claimed as a dependent on someone's else's tax return? YES NO

4. Have you, at any time, received the Shasta-Trinity Schools Insurance Group (STSIG) HSA contribution for enrolling in a high deductible plan? YES NO

By answering "NO" to the above questions, I certify that I am eligible to participate in a Health Savings Account. I further acknowledge receipt of the PayFlex Custodial Agreement and understand that a Health Savings Account (HSA) will be established in my name.

If any questions are answered "YES", I understand that I am ineligible to participate in Shasta-Trinity Schools Insurance Group Health Savings Account.

Employee Signature _____ Date _____

Employee Name (PRINT CLEARLY) _____

School District Name _____