

- New Application
 Change in Amount

**Yale University Benefits
2009 Health Savings Account (HSA)
Payroll Reduction Authorization**

(To be used with the Aetna Choice POS II High Deductible Health Plan)

Participant _____ Employment Date _____
(Last) (First) (Middle)

Department _____ Phone Number _____

Employee Number _____ **OR** SS#: _____

I hereby authorize Yale University to reduce my salary or wages during 2009 by the annual amount designated below to fund my HSA Account.

Up to \$3,000.00 per single coverage _____

Up to \$5,950.00 for 2 person/family _____

*One \$1,000 catch-up per account _____

Total amount _____

*Catch-up amount is for individual between ages 55 – 65 during 2009 calendar year.

Please deduct this annual amount during the 2009 calendar year as follows (Check one)

_____ Deduct during remainder of year _____ Deduct the entire amount in the first month

_____ Deduct over the first two months _____ Deduct over the first three months

HSA money will not be available until after it has been credited to your HSA account. Account is subject to approval by Aetna.

Note: *This salary reduction election is subject to the terms and conditions of Yale's cafeteria plan including any restrictions on pre-tax elections.*

Participants **cannot** be collecting social security and/or enrolled in Medicare A or B plan, or covered by another health plan (unless it is also a high deductible health plan or a plan providing specific, limited coverage), or claimed as a dependent on another person's tax return. I verify that eligible expenses will not be reimbursed through another plan such as a flexible spending account, and I understand that I must use my HSA money for qualified medical expenses including the deductible amount under my high deductible health plan.

Participant (Employee) Signature _____ Date _____

Send this form and the Aetna Health Fund HSA Enrollment forms to the Employee Service Center at:

Campus Mail: 221 Whitney Avenue
U.S. Mail: P.O. Box 208256, New Haven, CT 06520-8256

<i>Section to be completed by the Employee Service Center:</i>			
COVERAGE EFFECTIVE DATE _____	Processed by: _____	Oracle: _____	Vendor site: _____