

HOW TO SET-UP AN HSA ACCOUNT

WE MAKE
THE COMPLEX
SIMPLE

SETTING UP YOUR HEALTH SAVINGS ACCOUNT (HSA):

1. You must be enrolled in the City's High Deductible Health Plan (HDHP) to be eligible for an HSA.
2. You cannot be enrolled in Medicare A, B, C or D.
3. If your HDHP starts on a date other than January 1st, you are required to stay on the HDHP for one full year. Otherwise a 10% penalty and taxes will apply to any over contributions should you end your HDHP prematurely.
4. Note: the total employee and City contribution cannot exceed the IRS annual limits.
5. HSAs are Federally tax free. However, in California, HSA contributions are not tax deductible.
6. Your completed HSA Individual Application and Beneficiary Designation forms should be returned to HR & RM with the original "wet signature."

SERVICE PACKAGES & FEE SCHEDULE:

Choose between services packages - Standard & Value Plans

1. **Sterling Value Plan** – Offers a menu approach to select the services most important to Sterling account holders. Clients pay fees on a per services basis.
2. **Sterling Standard Plan** – The most complete range of administrative services for a monthly fee.

SERVICES	STANDARD PLAN	VALUE PLAN
Account Set-up Fees	-0-	-0-
Monthly Management Fees	\$8.75	\$2.50
Online Transactions	Included	Included
Medical Bill Paying		
Online Bill Pay	Included	\$5.00
Medical Bill Review and Scan/Archive	Included	Included
Debit Card Fees		
Card Issuance for Accountholder (first 2 cards)	Included	\$5.00
Card Issuance for Additional Cards (per card)	\$10.00	\$10.00
Usage (per transaction)	Included	\$1.50

All fees listed are per account. A \$20 fee is charged for account closures and to re-open a suspended account.

2021 MAX ANNUAL CONTRIBUTIONS (CITY & EMPLOYEE CONTRIBUTIONS)*:

HDHP COVERAGE	MONTHLY CITY CONTRIBUTION	SINGLE - \$3,600 Max Contribution		FAMILY - \$7,200 Max Contribution	
		City	Employee Max	City	Employee Max
Single Coverage	\$78.14	\$937.68 / year	\$102.39/pay per		
Double Coverage	\$125.02			\$1,500.24 / year	\$219.22/pay per
Family Coverage	\$156.27			\$1,875.24 / year	\$204.79/pay per

* City monthly contribution amounts listed above do not apply to IAFF and Unrepresented employees.

Note: For HSA purposes, a family is considered employee plus 1 or more coverage.



P.O. Box 71107
Oakland, CA 94612

1.800.617.4729
1.877.517.4729
www.sterlingadministration.com

HEALTH SAVINGS ACCOUNT INDIVIDUAL APPLICATION

Please check box if this application is being submitted for the purpose of establishing a spousal catch-up account for an already existing account. Please provide the number of the main account already established in Sterling HSA:

Account Number: _____

1. INFORMATION ABOUT YOU			
ACCOUNT HOLDER NAME	First Name	M.I.	Last Name <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.
MAILING ADDRESS	Address		City State Zip
CONTACT INFO	Telephone #	Email Address	
SOCIAL SECURITY #	DATE OF BIRTH	DRIVER'S LICENSE/PASSPORT <i>or other Government issued ID.</i>	
	/ /	<input type="checkbox"/> Driver's License <input type="checkbox"/> Passport <input type="checkbox"/> Other Number:	
2. INFORMATION ABOUT YOUR SPOUSE			<i>If applicable.</i>
NAME		SOCIAL SECURITY #	DATE OF BIRTH
First Name	M.I. Last Name <input type="checkbox"/> Male <input type="checkbox"/> Female		/ /
3. INFORMATION ABOUT YOUR HEALTH INSURANCE			<i>All fields required.</i>
HEALTH PLAN CARRIER	ANNUAL DEDUCTIBLE AMOUNT <i>(Please check Single or Family Coverage and enter the deductible amount you carry.)</i>	Effective Date of Health Plan	
Anthem Blue Cross	<input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage	Amount <i>(circle one)</i> \$3,000 / \$6,000	/ /
4. YOUR EMPLOYER INFORMATION			
NAME OF EMPLOYER	CONTACT INFORMATION		
City of Chico	Name Human Resources & Risk Management	Phone # (530) 879-7900	Email hr@chicoca.gov

5. INITIAL CONTRIBUTION AND SERVICE FEES*Please print clearly. All fields required.*

HSA CONTRIBUTION <i>(Voluntary/Optional. Must be paid by check to Sterling HSA)</i>	<ul style="list-style-type: none"> No minimum initial contribution Maximum Annual per IRS guidelines Maximum "catch up" contribution for age 55+ (in addition to above) 	\$
PLAN SELECTION	Please choose your preferred plan and enter the amount selected: <input type="checkbox"/> Standard Plan \$8.75/Month x 2 months = \$17.50 <input type="checkbox"/> Value Plan \$2.50/Month x 2 months = \$5.00	\$
TOTAL AMOUNT	<input type="checkbox"/> Deduct from employee account <input type="checkbox"/> Paid by an attached check to Sterling HSA <i>Please note: a minimum \$20 balance must be kept in the account at all times.</i>	\$

6. ADDITIONAL CONTRIBUTIONS

EMPLOYEE CONTRIBUTION (OPTIONAL)	Contribution Amount: \$	Contributions Amount is: <input type="checkbox"/> Per Pay Period <input type="checkbox"/> Monthly	Method of Payment: <input checked="" type="checkbox"/> Payroll
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7. DEBIT CARD REQUEST

<input type="checkbox"/>	Please order a Debit Card in my name. (One card will be mailed within 10 business days from the date of processing this application.)									
<input type="checkbox"/>	Please order a Debit Card for my dependent(s), listed below, and mail to my address. <i>(Additional charges may apply.)</i> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: left;">Name</td> <td style="width: 33%; text-align: left;">SS#</td> <td style="width: 33%; text-align: left;">Date of Birth</td> </tr> <tr> <td><hr/></td> <td><hr/></td> <td><hr/></td> </tr> <tr> <td><hr/></td> <td><hr/></td> <td><hr/></td> </tr> </table>	Name	SS#	Date of Birth	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
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8. ACKNOWLEDGEMENT / CUSTODIAL AGREEMENT*Required.*

This Subscriber Application Form, when signed by me and accepted by Sterling, acknowledges my receipt of the Sterling Administrative Agreement and the Custodial Agreement. I agree to be bound by the terms and conditions of the Custodial Agreement that may be amended from time to time. I further agree that I will be bound by any conditions or limitations regarding my Custodial Account established by Sterling. By signing this Subscriber Application Form, I consent to the sharing of financial and other information between me and Sterling and among Sterling's various affiliates. I acknowledge that summary information regarding Health Savings Accounts is available for informational purposes at "www.sterlingadministration.com".

(Accountholder's Signature)_____
(Date)*Please do not fax! Original signature must be received to avoid delay in processing your application.*



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BENEFICIARY DESIGNATION FORM

Account Holder Name: _____

Please check one of the following options:

- Initial Beneficiary Designation:** I designate the individual(s) or entity below as my primary and/or contingent beneficiary(ies) of this HSA.
- Replace Beneficiary(ies):** I designate the individual(s) or entity below as my primary and/or contingent beneficiary(ies) of the account named above and hereby revoke all prior beneficiary(ies) designations, if any, made by me.
- Add Beneficiary(ies):** I designate the individual(s) or entity below as my primary and/or contingent beneficiary(ies) of the above account. This list supplements, but does not replace, the beneficiary(ies) previously designated by me on the date specified. (When adding beneficiaries, if the share % of previously designated beneficiary(ies) changes, restate all beneficiary(ies) and the corresponding share % if the previous percentages are no longer correct.)

Beneficiary(ies):

The individual(s) or entity named in the below table shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survive me, the contingent beneficiary(ies) shall acquire the designated share of my account.

Name	DOB	Relationship	SSN #	Primary/ Contingent	%

Accountholder Authorization

I understand that I may change or add beneficiaries at any time by completing and delivering the proper form to Sterling HSA. Sterling HSA has provided no tax or legal advice to me regarding my beneficiary designation.

- I am not married** - I understand that if I become married in the future, I must complete a new Beneficiary Designation form.
- I am married** - I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign the Spousal Consent portion of this Beneficiary Designation form.

Accountholder Signature: _____

Date: _____



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BENEFICIARY DESIGNATION FORM - SPOUSAL CONSENT

Account Holder Name: _____

Spousal Consent

I, _____, am the spouse of the above-named Accountholder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this account, I have been advised to see a tax professional. I hereby give the Accountholder any interest I have in the funds or property deposited in this account and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. NO tax or legal advice was given to me by the Custodian.

Signature of Spouse: _____

Date: _____