



Health Savings Account (HSA) Enrollment

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Complete this form to enroll in an HSA account. Print clearly. Your HSA is your financial asset even if you change employers or health plans. You must meet the requirements under Internal Revenue Code Section 223 to be eligible to open and contribute to an HSA. This means that:

1. You must be covered by a qualified high-deductible plan.
2. You cannot be covered by another health plan, including Medicare or Flexible Spending Account. (You may be covered by a Limited Use Flexible Spending Account or Limited Use Health Reimbursement Arrangement.)
3. You cannot be claimed as a dependent on another individual's tax return.

Consult with your employer for more information about HSA eligibility requirements.

If you are an active employee, return this completed form to your employer.

Retirees and survivors, return to: ETF Retiree Health Insurance Unit, P.O. Box 7931, Madison, WI 53707-7931 or fax: 1-608-226-5535 or email RetireeHealth@etf.wi.gov.

Section 1: Application Information *Only the subscriber applying for coverage should complete this form.*

Name (first, middle, last, former/maiden)		Last 4 digits of SSN
Birth date (MM/DD/YYYY)	Telephone, including area code	Email
Address (Street, City, State, ZIP Code) <i>Note: Must be a valid U.S. street address; P.O. Box may not be used</i>		
If you are currently working - Employer name		If you are currently working - Employee ID
Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Enrollment status ☐ New enrollment ☐ Re-enrollment

Section 2: HSA Elections

If you are currently working (retirees *do not* complete this section):

Annual employer contribution: \$ _____

Annual employee contribution*: \$ _____ Number of regular pay periods: _____

Contribution per pay period: \$ _____ (this is your employee contribution divided by number of pay periods)

*The total employer and employee contributions cannot exceed IRS maximum limits.

For 2026, that limit is \$8,750 for employees with family HDHP coverage, \$4,400 for self-only coverage, and \$1,000 additional catch-up contribution for employees aged 55 or older.

For 2025, the limits were \$8,550 for family and \$4,300 for self-only.

Please note that your employer contributes \$852 for an individual plans and \$1,704 for a family plan, but only if you receive the employer share of the health premiums.

Section 3: Applicant Authorization

You certify the information on this form is correct, and is applying to open an Health Savings Account with the Wisconsin Department of Employee Trust Funds Third-Party Administrator (TPA). Once the HSA is opened, the TPA will serve as the custodian of your HSA, which consists of all the funds in your HSA deposit account, as well as any other investments you make with your HSA funds. You will receive a debit card linked to the HSA, subject to the Cardholder Agreement. You agree to return this form to your employer or benefits administrator and authorizes the TPA to share HSA details with the employer for account setup and maintenance.

Subscriber Signature	Date (MM/DD/YYYY)
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HSA Enrollment Terms and Conditions

I elect to participate in the Health Savings Accounts and agree to be bound by the terms of the Plan.

I understand that:

- The Health Savings Account (HSA) program is a benefit established for eligible state employees enrolled in one of the It's YourChoice (IYC) High Deductible Health Plans (HDHP). The HSA program is authorized under Internal Revenue Service (IRS) Code Sections §125, §105, and §223 and Wisconsin Statutes §40.515.
- A new enrollment must be completed each plan year. If I do not complete enrollment during open enrollment, I forfeit the opportunity to participate in the HSA benefit option.
- The annual HSA contribution amount I elect will be deducted from my paycheck on pre-tax basis. If I do not wish to have my HSA contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my human resource or benefit office.
- Pre-tax HSA contribution deductions reduce my compensation for Social Security benefit purposes.
- According to Wisconsin Statutes §40.87, participation in an HSA will not reduce my wages for calculating state retirement benefits. Also, my contributions in an HSA will not reduce my gross income for the purpose of calculating any other state benefits such as sick leave conversion credits, income continuation insurance, life insurance, deferred compensation, unemployment, or worker's compensation.
- Contributions made into one account cannot be transferred and used for expenses in any other account.
- Contributing to an HSA is completely voluntary, and I am solely responsible for determining whether any distribution from my HSA is in compliance with IRS regulations.
- Generally, contributions to an HSA are made on a month-to-month rule basis depending on what coverage I am enrolled in under the IYC HDHP on the first day of the month.
- There is a limited exception to the month-to-month rule described above. This exception allows me to make the maximum annual contribution for the plan year based on my enrollment in the IYC HDHP and HSA on December 1st. Assume I change from individual to family coverage during the second half of the year, I am limited to a maximum contribution under the month-to-month rule. Since I was enrolled in family coverage on December 1st, I can use the limited exception and can contribute the full family HSA contribution amount.
- **IMPORTANT NOTE:** In order to use this limited exception, I have to stay enrolled in the IYC HDHP and HSA at the same or higher level of coverage for the entire next plan year, called the 'testing period'. If I do not maintain this coverage, for instance I terminate employment or switch to a Non-HDHP the next plan year, then the excess funds contributed will be subject to a 6% excise tax.
- Eligible expenses must qualify as a health care deduction under the IRS.
- When I make a mid-year HSA contribution election or enrollment change, I am re-certifying to the terms and conditions.
- In circumstances where my Payment Card is lost/stolen or become aware of fraudulent charges, I will notify the TPA immediately.
- If I am found to have used my HSA or Payment Card

fraudulently, my participation in the state sponsored HSA may be terminated and I may lose the ability to participate in the state sponsored HSA benefit program in the future.

I certify that:

- The information I have provided is complete and accurate to the best of my knowledge.
- If the Bank Custodian is unable to verify my identity, the Bank Custodian may contact me for additional information, such as a copy of the driver license, W-2, Social Security Card, or other identifying documents. If I failed to not pass Customer Identification Program (CIP) within 90 days of the request, my HDHP will be reverted back to a non-HDHP and the HSA will be canceled.
- I am covered by one of the qualified IYC HDHP, and that I am not covered by any other non-permitted coverage.
- I have available to me a copy of the application and Custodial Agreement and Disclosure Statement and amendments thereto.
- I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions.
- I agree to have my compensation reduced by the contribution amount(s) I elected on a pre-tax basis. If I do not wish to have my HSA contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my human resource or benefit office.
- I have reviewed and understand the benefits program eligibility and enrollment information and I agree to abide by all participation requirements.
- All dependents listed meet the eligibility requirements of the program.
- I shall not claim a federal income tax deduction or credit for any expenses that were reimbursed through my HSA.
- I will inform my human resources benefit office as soon as reasonably possible when I am no longer eligible to contribute to the HSA, for instance if I obtain other non-permitted coverage such as coverage under my spouse's plan, and I understand any contributions made for any month in which I am not an eligible individual will be subject to an excise tax, and that my employer will deduct any contributions it made for such an ineligible month from my HSA.
- Use of the Payment Card will comply with the terms and conditions of the Cardholder Agreement received with the Payment Card.
- That all expenses charged on the Payment Card will qualify as reimbursable per IRS rules, will be incurred only for me or my eligible dependents, and will not be reimbursed through any other means, including my or my dependent's insurance plans.
- I will keep all receipts and other documentation related to expenses charged on the Payment Card for account management and tax purposes.
- I understand additional Payment Cards issued to my spouse or dependent(s) will provide the named individual with access to my HSA. I accept responsibility for all card transactions incurred by the named individual and will submit documentation, as requested, for those transactions.
- I acknowledge and agree that use of the Payment Card in violation of this enrollment agreement or the Cardholder Agreement may result in the invalidation and forfeiture of the Payment Card.