HEALTH SAVINGS ACCOUNT
CERTIFICATION OF HSA ELIGIBILITY

EMPLOYEE NAME:_____
(Last) (First) (Middle)

ADDRESS:_____
(Street) (City) (State) (Zip)

SOCIAL SECURITY NUMBER:_____ EMPLOYEE NUMBER:_____

EMPLOYER: _____ PLAN YEAR BEGINNING:_____

I understand to be eligible to contribute or have contributions made on my behalf to a health savings account I must meet all the following conditions:

1. I have ___ individual coverage or ____ family coverage under the group health plan sponsored by my employer, which I understand qualifies as a high deductible health plan ("HDHP") under section 223 of the Internal Revenue Code.
2. If I have coverage other than my coverage under the group health plan sponsored by my employer, that coverage is either (a) HDHP coverage; or (b) permitted non-HDHP coverage or insurance.
3. If I am married, my spouse does not have family coverage other than (a) HDHP coverage; or (b) permitted non-HDHP coverage or insurance.
4. I cannot be claimed as the tax dependent of another person.
5. I am not entitled to Medicare benefits.
6. I am responsible for determining the tax effect of contributions to my HSA by me or on my account and for determining the tax effect of distributions from my HSA.

By signing and submitting this form to my Employer, I certify that all of the above statements are true. I understand that I am not eligible for HSA contributions during any month in which I do not meet all of the HSA eligibility conditions. I also understand that my Employer will forward contributions to my HSA on my behalf on the basis of this certification and I will notify my Employer immediately in writing if I cease to meet any of the above conditions. I understand that all contributions to my HSA are subject to certain aggregate limits under federal tax law.

Date: _____ _____
Employee's signature