North Carolina Medical Society
Employee Benefit Plan

EMPLOYEE ENROLLMENT APPLICATION AND CHANGE FORM
HSA/HRA ADDENDUM

Statement of Understanding and Authorization:

The North Carolina Medical Society Employee Benefit Plan (“NCMS Plan”) offers High-Deductible Health Plan (“HDHP”) products that qualify its members to contribute to a Health Savings Account (“HSA”), unless the member is otherwise disqualified under federal law. The NCMS Plan also offers health plans that may be paired with a Health Reimbursement Account (“HRA”), funded by a member’s employer.

I understand that if I am applying for any health plan offered by the NCMS Plan, any associated HSA or HRA is provided to me directly by a separate administrator, unaffiliated with NCMS Plan, and is not part of the NCMS Plan. The NCMS Plan is not responsible or liable for administration of the HSA or HRA. Detailed information regarding my HSA or HRA will be provided by that administrator.

I understand that if my employer chooses an administrator for my HSA or HRA that has partnered with NCMS Plan, then NCMS Plan, my employer or their designees will share certain personal information about me with such administrator to facilitate the administrator’s establishment of the HSA or HRA account. By signing this application, I authorize NCMS Plan, my employer or their designees to share pertinent information with the administrator as applicable, which may include my name, address, social security number and my employer’s name.

I understand that if issued a debit card in connection with my HSA or HRA, I agree that NCMS Plan is not responsible or liable for administration of my debit card. The terms and conditions associated with my debit card are governed by my agreement with the bank issuing the card.

HSA ONLY: If I am applying for a HDHP to be used in conjunction with an HSA, I understand that NCMS Plan takes no responsibility for determining eligibility to contribute to an HSA and that I should consult a tax advisor if I have questions. By signing this application, I understand that I am authorizing the HSA Administrator to establish an HSA on my behalf, as of the date corresponding with the effective date of my HDHP with NCMS Plan. In order to activate the account, I will need to provide additional authorization through documents that will be provided to me by the HSA Administrator.

Employer Name: ____

Employee Signature: ________________________________ Date: __________

Print Employee Name: ____