HCSP Health Care Savings Plan
Our Tax-Free Solution

98946

Reimbursement Suspension Election Form
Plan Year - 2021

By completing this form you agree to suspend your ability to request reimbursements of medical expenses from the HCSP for the current calendar year. You may continue to request reimbursement of dental and vision expenses. Please review "Reason for Suspension" on the reverse side of this form to learn more.

1. Information about you

Last name	First name	MI	Account ID or SSN

Daytime phone	Retirement/Termination date

I am automatically reimbursed by my HCSP account each month for medical and/or long-term care insurance premiums.

❒ **YES** MSRS will stop your ongoing medical and long-term care insurance reimbursements. (Reimbursements of dental insurance premiums will continue.)

❒ **NO**

2. Account information

Please review Section B on the reverse side of this form to determine who the suspension applies to.

I am electing suspension of participation for the following (please check all that apply):

❒ Myself (HCSP participant)

❒ My spouse ______________________________
Name

❒ My legal tax dependent(s) and adult children up to their 26th birthday

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

3. Required signature (please sign below)

- Suspension of reimbursements from the HCSP account for the plan year indicated at the top of this form will prohibit me from receiving reimbursement of medical expenses incurred during the plan year, whether those claims are submitted during the current plan year or subsequent years.
- I may request reimbursement of dental and vision expenses.
- I cannot modify or revoke this suspension during the plan year indicated above.
- I understand that the Reimbursement Suspension Election form must be completed each plan year that I have access to my HCSP and a contribution is made to an HSA on my behalf.

Signature ______________________________ Date ____/____/____
Month Day Year

For MSRS use only
MSRS Plan Representative Signature ______________________________ Date ______________

Suspension Election Information

Important! It is only necessary for you to complete the Reimbursement Suspension Election form if you have both an HCSP and a Health Savings Account (HSA) and you meet the criteria described below in "Reason for Suspension."

A. Reason for Suspension

Once you are eligible to access your HCSP funds because you retired or left Minnesota public employment, you may not be able to contribute to an HSA.

However, if you, your spouse, or an employer wants to contribute to an HSA on your behalf during a calendar year in which you are eligible to access your HCSP funds, you should complete an HCSP Reimbursement Suspension Election form.

By completeing this form, you acknowledge that:

- during this calendar year, HCSP reimbursements are limited to vision and dental expenses.
- you can never be reimbursed for medical expenses incurred during the suspension period.
- the suspension expires at the end of the calendar year, after which time you cannot contribute to an HSA unless you suspend your HCSP access for another calendar year.

B. Electing the Suspension

Use the chart below to determine who the suspension applies to.

C. Removing the Suspension

You cannot modify or revoke this suspension during the plan year indicated on this form. The plan year is a calendar year running from January 1 to December 31.

The suspension is lifted on December 31 of the current calendar year. However, if you or your spouse or an employer will contribute to an HSA during the next calendar year, you must complete a new suspension form, which prohibits you from requesting reimbursements of medical expenses during the new calendar year.

D. Questions

Still not sure you need to suspend your HCSP this calendar year or have questions regarding the compatibility of the HCSP and HSA?

Please visit www.msrs.state.mn.us/hcsp or contact MSRS at the number below.

Contact your benefit provider if you have questions about your HSA.

Reimbursement of eligible vision and dental expenses are always allowable.

Who contributed to the HSA this calendar year?	What type of HSA?	The suspension applies to:
You or your employer	Individual	You
	Family	You, your spouse & dependents
Spouse or their employer	Individual	Your spouse
	Family	You, your spouse & dependents

Mail or fax the completed form to:

60 Empire Drive, Suite 300
St. Paul, MN 55103-3000

Toll-free: **1.800.657.5757**

Fax: **651.282.9909**

Teletypewriter users and telecommunications-device-for-the-deaf (TDD) users call the Minnesota Relay Service at 1.800.627.3529 and ask to be connected to MSRS at 651.296.2761.