

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	
<p>I am automatically reimbursed by my HCSP account each month for medical and/or long-term care insurance premiums.</p> <p><input type="checkbox"/> YES MSRS will stop your ongoing medical and long-term care insurance reimbursements. (Reimbursements of dental and vision insurance premiums will continue.)</p> <p><input type="checkbox"/> NO</p>			

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

An employee who has an HSA account can't generally make contributions to the HSA if they are eligible to access their HCSP account to reimburse qualified medical expenses. However, if you, your spouse, or an employer wants to contribute to an HSA on your behalf during this calendar year, you should complete an HCSP *Reimbursement Suspension Election* form.

By completing this form, you acknowledge that:

- during this calendar year, HCSP reimbursements are limited to vision and dental expenses.
- you can never be reimbursed from your HCSP account 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:



Minnesota State Retirement System
60 Empire Drive, Suite 300
St. Paul, MN 55103-3000



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.

ReimbursementSuspensionElectionHCSP/11.08.21