FTS INTERNATIONAL, LLC

HEALTH SAVINGS ACCOUNT CONTRIBUTION FORM

To contribute to a health savings account ("HSA"), and remain eligible for tax free medical reimbursements from my employer, FTS International, LLC ("FTS"), I hereby certify to FTS, with the knowledge and intention that FTS will rely on my certification, that:

- I am currently enrolled in a health plan that meets the minimum deductible level to be classified as an HDHP deductible (for 2024, $1,600 for self-only coverage or $3,200 for family coverage) and otherwise qualifies as an HDHP.
- **Effective March 1st, 2024, I have not and will not request reimbursement of medical expenses from FTS until I have satisfied the statutory minimum HDHP annual deductible (for 2024, $1,600 for self-coverage or $3,200 for family coverage) from my HSA or out of pocket.**
- I am not currently enrolled in Medicare, and I will immediately notify FTS if I enroll in Medicare.
- I was not claimed as a dependent on someone else's tax return during the preceding tax year.
- I have a validly-established HSA and am in all respects eligible to participate in and contribute to an HSA.
- The employer contribution requested below will not result in my total annual HSA contributions exceeding the applicable annual limit (for 2024, $4,150 for self-only coverage or $8,300 for family coverage, with additional catch-up contribution of $1,000 allowed for persons over 55 years of age).

Please check one:

☐ I plan to contribute to an HSA in 2024.

HSA FUNDING OPTIONS:	**IBA Conversion**	**Pay**
I authorize FTS to deduct a **recurring amount** my from my:	$_____	$_____
I authorize FTS to deduct a **one-time lump sum** from my:	$_____	$_____

Effective Date: _____

HSA BANKING DETAILS:

Routing Number:_____ Account Number: _____

☐ I will not contribute to an HSA in 2024 and this does not apply to me.

_____ _____

Print Name Employee Signature Date

I understand that my ability to receive contributions is dependent on the continued accuracy of these certifications. I agree to notify FTS immediately if any of these certifications become inaccurate, and I agree not to request any further contribution to my HSA if I am no longer able to honestly certify the above statements.

_____ _____

Print Name Employee Signature Date