2023 EMPLOYEE BENEFIT ENROLLMENT APPLICATION

(PLEASE PRINT)

WARNING: In order to secure benefit coverage with pre-tax costs, this form and all required dependent certification must be completed and returned to the myHR Team within 30 days of your date of hire or qualifying event date (including your date of hire or qualifying event date).

PLEASE NOTE—You have been provided with a Summary Benefit Comparison (SBC) for your eligible plans. This is considered as provided to your dependents as well. You may access the SBCs at **totalrewards.stryker.com/spd** or by requesting a hard copy from the myHR team.

TYPE OF ELECTION:

☐ New hire

☐ Change in status, due to (check one):

☐ Marriage	☐ Birth, adoption, legal guardian/foster child placement	☐ Day Care FSA change in need	☐ Divorce
☐ Dependent eligibility change	☐ Change in work schedule	☐ Domestic partner declaration	☐ Death
☐ Loss of coverage under another health plan	☐ Significant change in another plan	☐ Change in residence or work site	☐ Court Order
☐ Enrollment period under another plan	☐ Termination of domestic partnership	☐ Change of life insurance beneficiary only	☐ Stryker AE
☐ Employment status change	☐ Dependent moves to the United States from another country		

☐ Rehire (special enrollment rules may apply—refer to your summary plan descriptions for full details). **Special rules for rehires:** If you have a break in service (for example, due to termination of employment or due to taking a non-FMLA leave) during which you are not credited with any hours of service for at least 13 weeks, you will be treated as a new hire upon resumption of service. If the break in service is less than 13 weeks and you were enrolled in healthcare coverage and return during the same stability period or plan year, the coverage will be offered as soon as administratively practicable upon resumption of service. Further, you will be treated as a continuing employee upon resumption of service for purposes of any applicable measurement period.

COVERAGE EFFECTIVE DATE:

New Hire & Rehire: Date of hire or rehire is: _____

Change in Status: Date of the change in status is: _____

Coverage Effective Date (for myHR use only): _____

Note: Please provide proof of eligibility or status change (e.g., marriage certificate and last year's federal tax form, birth certificate, baby bracelet, baby hospital footprints, adoption papers, court document, divorce decree, loss of coverage verification, declaration or termination of domestic partnership, etc.)

EMPLOYEE INFORMATION:

Employee Name (First, MI, Last)	Social Security Number	Date of Birth (mm/dd/yy)	Date of Hire (mm/dd/yy)
Street Address	**City and State**	**Zip Code**	**Gender (M/F)**

HEALTHCARE PLANS (healthcare benefits include medical, prescription drug (Rx), dental and vision coverage):

You Are Eligible for:	Medical and Rx Plan Coverage Options	Select One	Monthly Employee Costs (Before-Tax)[1] Full-Time	Part-Time
	No Coverage (Check to Waive Coverage)[2]			
UnitedHealthcare (UHC) Choice PPO Plan				
	Employee Only		$154	$186
	Employee + Spouse/Domestic Partner or Employee + Child		$301	$375
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$472	$582
UnitedHealthcare (UHC) Value PPO Plan				
	Employee Only		$135	$170
	Employee + Spouse/Domestic Partner or Employee + Child		$262	$336
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$413	$524
UnitedHealthcare (UHC) Out-of-Area PPO Plan				
	Employee Only		$150	$182
	Employee + Spouse/Domestic Partner or Employee + Child		$294	$367
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$461	$569

UnitedHealthcare (UHC) Premium HSA Plan				
	Employee Only		$117	$149
	Employee + Spouse/Domestic Partner or Employee + Child		$220	$291
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$349	$457
UnitedHealthcare (UHC) Basic HSA Plan				
	Employee Only		$63	$63
	Employee + Spouse/Domestic Partner or Employee + Child		$84	$84
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$115	$115
Kaiser Northern CA HMO (live or work in No. CA)				
	Employee Only		$165	$202
	Employee + Spouse/Domestic Partner or Employee + Child		$302	$375
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$475	$586
Kaiser Southern CA HMO (live or work in So. CA)				
	Employee Only		$143	$172
	Employee + Spouse/Domestic Partner or Employee + Child		$252	$312
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren)*		$374	$459

Hawaii Medical Services Association (HMSA) (for eligible Hawaii residents)				
	Employee Only		$30	$30
	Employee + Spouse/Domestic Partner or Employee + Child		$290	$361
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$451	$559
Blue Cross Blue Shield of Alabama (for eligible Alabama residents)				
	Employee Only		$164	$164
	Employee + Spouse/Domestic Partner or Employee + Child		$302	$302
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$446	$446

You Are Eligible for:	Dental Plan Coverage	Select One	Monthly Employee Costs (Before-Tax)[1] Full-Time	Part-Time
	No Coverage (Check to Waive Coverage)[2]			
Delta Dental				
	Employee Only		$20	$20
	Employee + Spouse/Domestic Partner or Employee + Child		$40	$40
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$60	$60

You Are Eligible for:	Vision Plan Coverage	Select One	Monthly Employee Costs (Before-Tax)[1] Full-Time	Part-Time
	No Coverage (Check to Waive Coverage)[2]			
EyeMed Vision Care				
	Employee Only		$5	$5
	Employee + Spouse/Domestic Partner or Employee + Child		$10	$10
	Employee + Children or Employee + Family *(Employee + Spouse/Domestic partner + Child(ren))*		$15	$15

[1]Domestic Partners, and their eligible dependents, enrolling due to a dependent moving to the United States from another country and late enrollment costs are deducted on an after-tax basis per IRS regulations.

[2]I understand that to enroll outside of the Annual Enrollment period I must experience a qualifying change in status as per the Summary Plan Description (SPD) and any applicable Summary of Material Modification (SMM).

You and Stryker share in the cost of healthcare benefits for you and your family. If you enroll in Stryker's healthcare plan and provide proper documentation within 30 days of the event (including the date of the event), Stryker will deduct the required employee costs from your wages on a before-tax basis. Costs for Domestic Partners, their eligible dependents and late enrollees are deducted on an after tax-basis.

Costs are subject to change annually.

HEALTHCARE PLAN DEPENDENT ENROLLEES (skip this section if health coverage is NOT wanted):

List all dependents that you wish to enroll or drop from the healthcare plan. **Proof of eligibility is required**. If you are enrolling a domestic partner contact the myHR Team to obtain the necessary paperwork. Please note that dependents can only be enrolled if you are also enrolled in the plan.

☐ **Adding Enrollee(s)** ☐ **Deleting Enrollee(s)**

First Name	MI	Last Name	Social Security Number (Required)	Relationship (See Codes Below)	Date of Birth (mm/dd/yy)	Gender (M/F)	Medical and Rx Coverage (Y/N)	Dental Coverage (Y/N)	Vision Coverage (Y/N)

Relationship Codes: **B** – Spouse **C** – Son, Stepson, Legal Guardian/Foster Son **D** – Daughter, Stepdaughter, Legal Guardian/Foster Daughter
E –Domestic Partner **F** –Domestic Partner's Son **G** –Domestic Partner's Daughter **H** – Disabled Son **I** – Disabled Daughter

TOBACCO USE AFFIDAVIT—FOR EMPLOYEES ENROLLING IN MEDICAL PLAN COVERAGE (you must complete this affidavit to avoid the annual $600 Tobacco Surcharge. If this Tobacco Affidavit is not completed, you will be considered a tobacco user under the Tobacco Cessation Program, regardless of your tobacco use):

I am aware that Stryker charges a $600 annual Tobacco Surcharge to an employee if the employee and/or his or her spouse/domestic partner is a tobacco user, is covered by the Stryker medical plan and the tobacco user has not completed a Strive tobacco cessation Journey, or other physician-recommended program, in the current calendar year.

I have read the terms of the Tobacco Cessation Program and represent and warrant that the declaration made in this document is accurate for me and any applicable spouse/domestic partner. I understand that the definition of a tobacco user is someone who used tobacco products during the last six months, including but not limited to cigarettes, cigars, pipes, ecigarettes, chewing tobacco and snuff. A person who used tobacco products as identified above at the rate of once per month or less on average (such as an occasional celebratory cigar) is not considered a tobacco user.

After reading the information provided, I hereby certify that:
[You must check only one box.]

*One of the following three items must be marked if you are **not** covering a spouse or domestic partner on your medical plan in 2023:*

- ☐ I am a tobacco user
- ☐ I am a tobacco user and completed a Strive tobacco cessation Journey, or other program recommended by my physician, in this calendar year
- ☐ I am not a tobacco user

*One of the following four items must be marked if you **are** covering a spouse or domestic partner on your medical plan in 2023:*

- ☐ One or both of us is a tobacco user
- ☐ Both of us are tobacco users and we both have completed a Strive tobacco cessation Journey, or other program recommended by our physician, this calendar year
- ☐ Only one of us is a tobacco user, and the tobacco user has completed a Strive tobacco cessation Journey, or other program recommended by our physician this calendar year
- ☐ We are both not tobacco users

I understand that by certifying myself or, if applicable, my spouse/domestic partner as tobacco user(s) I will be charged the Tobacco Use Surcharge in 2023 if the tobacco user has not completed the a Strive tobacco cessation Journey, or other program recommended by my physician, in the current calendar year.

I understand that tobacco user(s) can remove the Tobacco Use Surcharge by completing a Strive tobacco cessation Journey, other program recommended by my physician or by confirming via the affidavit that they have quit using tobacco for a period of 6 months prior to the signature date. I understand that the Tobacco Surcharge will be removed within two pay periods of completing the follow up affidavit on the Benefits Enrollment Site, and that I am eligible for retroactive reimbursement of the Tobacco Use Surcharge for that year. I understand that, in the event that both myself and my spouse/domestic partner are tobacco users, we both must enroll in and complete a Strive tobacco cessation Journey, or other program recommended by my physician, to qualify for removal of the Tobacco Use Surcharge**.** Enroll in a Strive tobacco cessation Journey by visiting strive.stryker.com.

I understand that if I do not complete this Tobacco Affidavit I will be considered a tobacco user, regardless of my tobacco use.

I understand Virgin Pulse, the vendor of Strive, may identify, by name, participants who have completed a Strive tobacco cessation Journey to the Corporate Total Rewards department.

I understand that falsification of this information may subject me to retroactively pay the Tobacco Use Surcharge and may result in disciplinary action, up to and including termination from employment.

FLEXIBLE SPENDING ACCOUNTS (FSAs):

Stryker offers two Flexible Spending Accounts (FSAs). Your account elections are voluntary. Enter your total calendar year contribution amounts below.

Flexible Spending Account Options[1]	Total Annual Contribution Amount (Before-Tax)	NOTE:
Healthcare Flexible Spending Account (HCFSA) *(Reimbursement for healthcare expenses.)*	$_____	If you decide to participate, your calendar year healthcare spending account contribution must be between $100 and $2,850.
Day Care (Child and Adult) Flexible Spending Account (DCFSA)[2] *(Reimbursement of child and elder care expenses.)*	$_____	If you decide to participate, your calendar year day care (child and adult) flexible spending account contribution must be between $100 and $5,000, or $2,500 if you are married and file a separate income tax return.

[1]Due to IRS regulations, expenses for Domestic Partners and/or their child(ren) are only eligible for reimbursement if they are tax dependents. For more information, visit www.irs.gov and see Publication 502 for questions about the Healthcare Flexible Spending Account (HCFSA) or Publication 503 for questions about the Dependent Care (Child and Adult) Flexible Spending Account (DCFSA).

[2]Qualifying individuals include your child under age 13 who resides with your for more than half the year and can be claimed as a tax dependent, and (if applicable) your spouse or other tax dependent who is physically or mentally incapable of self-care and resides with your for more than half the year.

HEALTH SAVINGS ACCOUNT (HSA):

Stryker offers a health savings account (HSA) to employees who elect the UHC Basic HSA and Premium HSA Plans. In 2023, Stryker also makes a contribution to your account to help pay your eligible healthcare expenses. See the table below for the Stryker contribution amounts. Your own account contribution elections are voluntary. Your HSA can be used to pay for eligible healthcare expenses incurred by you, your spouse, tax dependent or qualifying child/relative. For more information, visit **www.irs.gov** and see Publication 502. Enter your total calendar year contribution amounts below (not including the employer contribution). **Note:** You must complete the Authorized Agent Agreement on page 12 if electing the health savings account. If you do **not** wish to open an HSA, you must complete the HSA Account waiver on page 13.

Total Before Tax Annual Contribution Amount* (not including the Stryker employer contribution)	**NOTE:** If you decide to participate, your contribution and Stryker's total annual contribution amount must not exceed the 2023 IRS contribution limits, as follows:		
	Coverage level	**Stryker's 2023 Contribution**	**Your Total 2023 Personal Contribution Limit (including your contribution and Stryker's):**
		UHC Basic HSA Plan / **UHC Premium HSA Plan**	
$_____	Employee only	$300 / $600	$3,850
	All other coverage tiers	$600 / $1,200	$7,750
	Catch-up contributions**	N/A / N/A	$1,000

While eligible HSA contributions and withdrawals are tax-free at the federal level, they are not exempt from state tax in some states (currently California and New Jersey). If you live in one of these states, you can still contribute to an HSA and receive the federal tax benefits. For more information, visit **www.irs.gov or your state's Department of Revenue, or consult your financial/tax advisor.*

***Employees age 55 or older can make an additional $1,000 per year catch-up contribution.*

***Note:** There are certain restrictions if you have other coverage or if you are not enrolled in an HSA-eligible plan for the entire year. For example, through your spouse or domestic partner, or if they also have an HSA-compatible plan offered through his or her employer. For more information, contact your myHR team.*

*Under the "last-month rule," you are considered to be an eligible individual for the entire year (and can contribute up to the full IRS maximum in your HSA) if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers). Employees must be enrolled in HSA-compatible coverage by December 1 to be eligible to make full HSA contributions for the current tax year. You must remain eligible for HSA contributions for the next 12 months (generally, through December 31 of the following year) for contributions to remain tax-free. If you become ineligible during the 12-month period (e.g., enroll in a non HSA-compatible health plan), contributions will become taxable and subject to an additional 10% penalty tax. Eligible individuals enrolling in an HSA-compatible plan between December 2 and December 31 are not eligible to make health savings account contributions on a tax-advantaged basis for the current tax year, and will not be eligible for the Stryker contribution for the current plan year. Visit **www.irs.gov** and see Publication 969 for more details.*

DISABILITY AND LIFE INSURANCE:

Stryker provides you with basic term life and accidental death and dismemberment (AD&D) insurance, which are paid in full by Stryker. Your basic coverage amount for both life and AD&D is equal to one times your annual benefit salary. The maximum coverage under the basic life insurance plan is $500,000. The maximum AD&D coverage is also $500,000. Stryker also provides you with Company paid Short term disability (STD) and Company paid Long term disability (LTD). For details on how the life insurance benefit is paid, view the Life Insurance certificate.

SUPPLEMENTAL LIFE INSURANCE (full-time employees only):

If you are a full-time employee, you can supplement your Stryker-provided life insurance coverage by purchasing supplemental term life insurance. You can purchase supplemental life insurance in increments of one (1) to five (5) times your annual benefit salary. The maximum coverage permitted by the plan is $1,500,000. Age rated premium costs are shown below.

Supplemental Life Insurance Premium Rates per $1,000 of coverage AGE IS STATED IN YEARS AND BASED ON YOUR AGE AS OF JANUARY 1, 2023											
AGE	0 – 24	25 – 29	30 – 34	35 – 39	40 – 44	45 – 49	50 – 54	55 – 59	60 – 64	65 – 69	70+
RATE	$0.03	$0.03	$0.03	$0.04	$0.06	$0.10	$0.16	$0.26	$0.35	$0.54	$.94

Calcuation example (for reference only – you do not need to complete the calcuation):

_____	÷ $1,000 =	_____	x _____	= _____
(Your Annual Benefit Salary)			(amount listed under your age range above)	This is the estimated monthly amount for 1x in supplemental life insurance. If you will be electing a higher multiple, multiply your monthly amount for 1x by that multiple.

If you purchase supplemental life insurance, your cost will be deducted from your paycheck on an after-tax basis. Indicate below whether you want to purchase supplemental group term life insurance.

I want to purchase: ☐ 1 x, ☐ 2 x, ☐ 3 x, ☐ 4 x, ☐ 5 x (x = times my annual benefit salary).

☐ No change to my current coverage ☐ I do not want to purchase supplemental life insurance at this time.

Special rules for employees previously eligible for supplemental life insurance within the past 13 weeks. If you were previously eligible for supplemental life insurance coverage but lost eligibility under the plan due to separation of service, status change, etc. and you become eligible for Stryker's plan again within 13 weeks of your original loss of eligibility date, the amount of supplemental life insurance reinstated will be the amount of coverage in force at the time of termination of coverage. Indicate below whether you would like your prior coverage reinstated.

☐ Reinstate my prior approved coverage. ☐ I do not wish to purchase supplemental life insurance.

Evidence of Insurability

Evidence of insurability (EOI) is required if your supplemental life insurance coverage amount is greater than $500,000. Refer to your summary plan description for full details. If you apply for an amount of supplemental life insurance that requires evidence, an evidence of insurability questionnaire will be sent to you from The Hartford after you have completed the enrollment process. In addition to completing the questionnaire, the insurance company may ask you to undergo blood tests or other tests. In some cases, a physical exam may be required. You are responsible for the cost of these services. **Amounts of coverage subject to EOI review will go into effect on the date of approval by the carrier.**

LIFE INSURANCE BENEFICIARY INFORMATION (this section is REQUIRED even if you do not elect supplemental life insurance. Basic and supplemental life insurance beneficiaries will be the same):

PRIMARY BENEFICIARY			
Name	**Relationship**	**Date of Birth**	**Percentage of Benefit** (Must Equal 100%)
SECONDARY BENEFICIARY (IF PRIMARY BENEFICIARY NOT LIVING)			
Name	**Relationship**	**Date of Birth**	**Percentage of Benefit** (Must Equal 100%)

Spousal Consent: If you are a resident of the state of AK, AZ, CA, ID, LA, NV, NM, TX, WA or WI and you designate someone other than your spouse as your beneficiary, your spouse must consent below to your beneficiary designation.

I hereby consent to the beneficiaries named above by the employee, my spouse.

Spouse's signature: _____ Date: _____

SPOUSE AND/OR DEPENDENT LIFE INSURANCE (full-time employees only):

If you are a full-time employee, you may choose to elect life insurance for your spouse/domestic partner and/or children. Spouse/domestic partner life insurance can be elected in $10,000 increments up to a maximum of $100,000. Evidence of insurability will be required for amounts in excess of $30,000. Child life insurance is $10,000 for each of your children, regardless of the number of children you currently have. You will pay the full cost of the life insurance coverage on an after-tax basis. Your dependents do not need to be enrolled in Stryker's healthcare plan in order to be eligible for dependent life insurance. Disabled Dependents are not eligible for this coverage. The beneficiary is automatically the employee.

Indicate below whether you would like to purchase dependent life insurance. Spouse/domestic partner demographics will be required. Child demographic information is not required if you are electing child life insurance.

I want to purchase:

Spouse/Domestic Partner Coverage:

- ☐ No Coverage
- ☐ $10,000 Coverage ($1.28 per month)
- ☐ $20,000 Coverage ($2.57 per month)
- ☐ $30,000 Coverage ($3.85 per month)
- ☐ $40,000 Coverage ($5.13 per month)
- ☐ $50,000 Coverage ($6.42 per month)
- ☐ $60,000 Coverage ($7.70 per month)
- ☐ $70,000 Coverage ($8.98 per month)
- ☐ $80,000 Coverage ($10.26 per month)
- ☐ $90,000 Coverage ($11.55 per month)
- ☐ $100,000 Coverage ($12.83 per month)

Child/Children:

- ☐ No Coverage
- ☐ $10,000 Coverage ($1.04 per month)

Spouse/Domestic Partner Life Coverage Enrollee (required if you are electing spouse life insurance):

First Name	MI	Last Name	Relationship (Spouse or Domestic Partner)	Date of Birth (mm/dd/yy)	Gender (M/F)

EMPLOYEE ACKNOWLEDGEMENT (signature is REQUIRED for ALL EMPLOYEES completing the enrollment form):

I hereby request the coverage that I have elected and hereby authorize Stryker to deduct the required employee costs from my earnings. I acknowledge that my supplemental group term life volume, if any, will increase each year as my benefit salary increases, as long as any evidence of insurability requirements have been satisfied, and that the premium withheld from my earnings will increase accordingly and as my age advances. I acknowledge that if I take an unpaid leave of absence from my position, my premiums will be collected from my first paycheck(s) upon my return to work. I further acknowledge that changes in these elections can be made only in the event of a qualified status change or during annual enrollment.

By signing this, I certify that all of the information is correct and accurate. I understand that failure to provide accurate information may result in denial of benefits and other disciplinary action up to and including termination of employment.

Employee Signature: _____ Date: _____

KAISER EMPLOYEE ACKNOWLEDGEMENT (signature is REQUIRED if enrolling in a KAISER PERMANENTE PLAN)

Kaiser Foundation Health Plan, Inc., Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

Appointment of Stryker as Authorized Agent to Open an HSA

EMPLOYEE INFORMATION:

First Name | Middle Initial | Last Name

Residential Street Address (Not P.O. Box) | City | State | Zip Code

Home Phone Number | Date of Birth (mm/dd/yyyy) | Social Security Number

Country of Citizenship | Residency Status
(US Citizen or Permanent/Resident Alien or Non-Permanent/Non-Resident Alien)

APPOINTMENT AND CERTIFICATION (signature is REQUIRED for all employees electing the UHC Premium HSA Plan or UHC Basic HSA Plan):

By signing below, I appoint Stryker as my agent for the purpose of opening and administering/maintaining an Optum Bank, Inc. ("Bank") Health Savings Account ("HSA") on my behalf and authorize Stryker to send and receive information to and from the Bank on my behalf (including account number) in order to accomplish this purpose. I authorize the Bank to make any inquiries that it considers appropriate to determine if it should open and maintain my HSA, and I acknowledge that I have received the Bank's USA PATRIOT Act Notice provided below:

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

I certify that I am eligible to contribute to an HSA under Internal Revenue Code Section 223. I authorize and direct the Bank to issue a Debit MasterCard® to me. I certify that I have received or viewed the Bank's statement of the hardware and software requirements for access to and retention of electronic records and that I have the ability to access the Bank's website where electronic statements and other documentation are stored. I instruct the Bank, unless otherwise notified and instructed by me, to provide the Custodial and Deposit Agreement and all other HSA notices, disclosures and information related to and governing my HSA to me online at **www.optumbank.com**. I understand that monthly account statements and other documentation and notices will be delivered or made available electronically. If I want HSA statements mailed to my home, I must notify the Bank directly.

I agree that Stryker will remain my agent unless and until Stryker and the Bank receive notice that the appointment of Stryker as my agent has been terminated, that I am no longer employed by Stryker, or that I am no longer an HSA eligible individual; or I receive a notice from the Bank that my application for an HSA has been declined.

_____ _____

Employee Signature | Date

Optum Bank Access to and Retention of Electronic HSA Records

To view the Bank's hardware and software requirements, instructions for viewing and downloading copies of electronic documents, and instructions for updating an email address, please visit **www.optumbank.com/terms-of-use**.

Health Savings Account Waiver

Complete only if you are newly enrolling in the UHC Basic HSA or Premium HSA medical plan and you do NOT wish to open a Health Savings Account.

I, _____, have enrolled in Stryker's UnitedHealthcare (UHC) Basic HSA or UHC Premium HSA medical plan effective _____.

I am declining to open a Health Savings Account (HSA) with Optum Bank for the calendar year in which my election is effective.

By waiving the option to open a Health Saving Account with Optum Bank, I understand the following:

- I will not be able to contribute to the Optum Health Savings Account through pre-tax payroll deductions at Stryker throughout the current plan year.
- I will not be eligible to receive the Stryker HSA employer funding for the remainder of the plan year in which I have enrolled in the above medical plan, even if I open the HSA account with Optum Bank in another plan year.
- I must contact the myHR team each annual enrollment period (or within 30 days of a qualifying life event) in order to waive the opening of a Health Savings Account for each year that I remain in, or elect an HSA medical plan option.

I must contact the myHR team each annual enrollment period (or within 30 days of a qualifying life event) in order to waive the opening of a Health Savings Account for each year that I remain in, or elect an HSA medical plan option.

_____ _____

Employee Signature Date

_____ _____

Printed Name Employee Workday ID Number

For Stryker myHR Benefits Team Completion Only:

_____ _____

myHR Benefits Team Member Name Date Received

_____

Date Processed