

HEALTH SAVINGS ACCOUNT

PAYROLL CONTRIBUTION ELECTION FORM

Change Contribution Amount

Stop Contribution Amount

By signing this form, I authorize my employer to deduct, stop or change the elected amount from my pay on each pay date. I hereby consent that all personal information and selections made are correct.

Signature _____

Date signed _____

LAST NAME FIRST NAME MI EMP ID# (last four S S #)

COMPLETE MAILING ADDRESS (Include city, state,zip)

DATE OF BIRTH DATE OF EMPLOYMENT HOME PHONE

I elect to have the following amount deducted **per pay period** \$ _____ *

Start Date : _____ **Stop Date**: _____

I understand the actual date of change could vary depending on when the form is received in the treasurer's office.

* Contributions limits: Your annual HSA contributions cannot exceed the statutory IRS contribution maximums. If you are age 55 or older, you can make additional "catch up" contributions of up to \$1,000. Please refer to the Department of Treasury website for more details: <http://www.treas.gov/offices/public-affairs/hsa/>