



# Health Savings Account

## Salary Reduction Agreement 2024-2025 Plan Year

Effective Pay Date: \_\_\_\_\_

- Begin New HSA Contribution
- Change to Current HSA Contribution

**Employee Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

**Insurance Plan: Enrollment Status:**

Sutter Health Plus HDHMO 1600/3200	<input type="checkbox"/> Single	<input type="checkbox"/> Family
Sutter Health Plus HDHMO 2500/5000	<input type="checkbox"/> Single	<input type="checkbox"/> Family
Western Health Advantage HDHMO 1800/3600	<input type="checkbox"/> Single	<input type="checkbox"/> Family
Western Health Advantage HDHMO 2800/5600	<input type="checkbox"/> Single	<input type="checkbox"/> Family
Kaiser HDHMO 2000/4000	<input type="checkbox"/> Single	<input type="checkbox"/> Family
Kaiser HDHMO 3000/6000	<input type="checkbox"/> Single	<input type="checkbox"/> Family
Blue Shield PPO Savings 2700/5200	<input type="checkbox"/> Single	<input type="checkbox"/> Family
Blue Shield PPO Savings 4400/8800	<input type="checkbox"/> Single	<input type="checkbox"/> Family

**2024 IRS Contribution Limits:**

Single Coverage	Family Coverage	Age 55 or over Catch Up
\$4,150 (\$345.83 Dist. Monthly Max)	\$8,300 (\$691.67 Dist. Monthly Max)	\$1,000 (\$429.17 Single/\$775.00 Family Dist. Monthly Max)

<i>Will you be age 55 or older as of 6/30/24?</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>If 55 or older, will you be including a catch up contribution?</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**IRS contribution limits are reduced by any employer contributions. The employer contribution is the unused portion of your monthly district benefits cap, if applicable, not to exceed IRS (district) limits.**

**Recurring Contributions:**

Monthly Employer Contribution	\$ _____
Monthly Employee Contribution	\$ _____
<i>Total Monthly Contribution</i>	\$ _____

**One-Time Employee Contribution:**

<b>Amount:</b> \$ _____	<b>Effective Date:</b> _____	<b>After this contribution, recurring contributions to HSA should be:</b> <input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
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Please note: Our plan year for benefits is July through June, but contribution limits are January through December. Since December payroll is paid in January, the last contribution for each calendar year is November.

**I do hereby authorize Western Placer Unified School District to deduct the stated amount from my pay warrant and deposit it into the custodial account with OPTUM Bank.**

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

District Approval \_\_\_\_\_

Date \_\_\_\_\_

*\*For any questions related to various tax implications or conflicts if collecting Social Security or enrolled in Medicare Part A or B, please consult your tax advisor regarding your individual situation.*