Flushing Community Schools
Mid-Year Health Savings Account Election Change Form
Plan Year: July 1, 2023 – June 30, 2024

PERSONAL INFORMATION

First Name	Last Name		Last 4 Digits of SSN
Street	City	State/Zip	Home Phone Number

HEALTH SAVINGS ACCOUNT CONTRIBUTIONS (I am currently enrolled in the "high deductible health plan" and am an "eligible individual", as those terms are defined by the Internal Revenue Code.)

PLEASE CHECK ONE.

CHANGE IN PER PAY CONTRIBUTIONS

This notification is to change the amount of my HSA contributions from $_____ per pay to $_____ per pay effective on _____.
(date)

DISCONTINUE PER PAY CONTRIBUTIONS

Please discontinue my HSA contributions effective on _____.
(date)

I understand that the total contributions to my health savings account cannot exceed IRS limits.

I hereby authorize my employer to adjust my salary on a pre-tax basis by the amount of my benefit election(s) specified above.

_____ _____
Employee Signature Date