



Health Savings Account Enrollment/ Change Form

EMPLOYER MUST FILL-IN

Re-enrollment New Change
Effective Date _____
1st Deduction Date _____
Payroll Mode B M

Personal Information (Please print clearly and provide complete and accurate information.)

Your Employer _____ Social Security(last 4)# _____

Your Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth / /

Effective Date _____

All fields must be complete in order to enroll

BENEFIT CHOICES

**PER PAY PERIOD
AMOUNT**

Health Savings Account (HSA)

- The minimum & maximum contribution amounts are determined by your employer.

Employee payroll deduction: \$ _____

I understand that:

- I am able to change my HSA contribution at any time by contacting my benefits department.
- This election will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code.
- Any amount in my HSA may roll over to following years.
- Social Security and Medicare taxes are not being withheld on the amount of my salary reduction under this election.
- The amount of salary reductions may not be claimed on my or my spouse's income tax returns.
- If my employment terminates, my HSA is portable and I can take my funds with me.

 **Employee Signature** _____ **Date** _____