Health Savings Account Enrollment/ Change Form

EMPLOYER MUST FILL-IN		
Re-enrollment	New	Change
Effective Date ______________		
1st Deduction Date ___________		
Payroll Mode	B	M

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

Your Employer____ **Social Security #**______________________________

Your Name ____
(Last) (First) (M)

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:	$________.____
Employer Contribution:	$________.____

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 will 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*** ____________________