Health Savings Account Payroll Deduction Form

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Processing may be delayed if fields with an asterisk are not filled out.

Step 1 Consumer information (employee)

* Consumer first name	M.I.	* Last name		
* Date of birth	* Social security number		* Day telephone	
* Physical address		* City	* State	* ZIP
* Hire date		* Employee ID		
* Email address				

Step 2 High Deductible Health Plan (HDHP) coverage level

* HDHP coverage level ☐ Single ☐ Family	* HDHP coverage date (Effective Date)

Step 3 Contribution information

Note: If your employer makes contributions to your HSA that amount will apply to the IRS annual contribution limit and should be taken into consideration when determining how much you will contribute to our HSA account. You are solely responsible for determining whether contributions to an HSA exceed the maximum annual contribution limitation.

Plan year (01/01/22-12/31/22)	Annual election (Single $3150.00, Family $6800.00 maximum)
Per pay period deduction (divide annual election by the number of pay periods)	

Step 4 Accountholder authorization

By signing this application, I represent that: 1.) I am covered under a high deductible health plan (HDHP); 2.) I am not covered by any other health plan that is not an HDHP; 3.) I am not enrolled in Medicare and 4.) I cannot be claimed as a dependent on another person's tax return. I understand that if my spouse is enrolled in a general-purpose FSA (a non-HDHP) I am not eligible to contribute to an HSA. I understand that my HSA cannot be effective prior to my HDHP coverage date. 5.) I authorize my employer to deduct the elected amount from my pay on each pay date. I hereby consent that all personal information and selections made are correct. I acknowledge that this form may be electronically signed and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

* Accountholder signature	* Date

Please return to your human resources or benefit department upon completion.