HEALTH SAVINGS ACCOUNT PAYROLL DEDUCTION FORM

INSTRUCTIONS: Please return the completed form to your agency payroll department.

STEP 1: Customer Information

Name *(First, MI, Last)*	
Address	
Daytime Phone	
Email Address	
SSN	
Birth Date *(mm/dd/yyyy)*	
Employee ID	
Hire Date	

STEP 2: High-Deductible Health Plan (HDHP) Coverage Level

There may be tax consequences if HSA contributions exceed the IRS governed limit.

HDHP Coverage Level	☐ Single ☐ Family	HDHP Coverage Date	

STEP 3: Contribution Information

I elect an annual contribution of $_____ for calendar year _____. See table below for guidance. The annual amount elected will be divided equally among your payroll periods. The table below shows examples of the amount you would need to contribute each payroll period in order to reach various annual contribution amounts.

	Annual Contribution	Payroll Withholding			
		Weekly	Bi-weekly	Semi-monthly	Monthly
	$550.00	$10.58	$21.15	$22.92	$45.83
	$1,000.00	$19.23	$38.46	$41.67	$83.33
	$1,500.00	$28.85	$57.69	$62.50	$125.00
	$2,000.00	$38.46	$76.92	$83.33	$166.67
	$2,500.00	$48.08	$96.15	$104.17	$208.33
	$3,000.00	$57.69	$115.38	$125.00	$250.00
2027 Single Maximum	**$4,500.00**	$86.54	$173.08	$187.50	$375.00
	$5,000.00	$96.15	$192.31	$208.33	$416.67
	$5,500.00	$105.77	$211.54	$229.17	$458.33
	$6,000.00	$115.38	$230.77	$250.00	$500.00
	$7,000.00	$134.62	$269.23	$291.67	$583.33
	$8,000.00	$153.85	$307.69	$333.33	$666.67
2027 Family Maximum	**$9,000.00**	$173.08	$346.15	$375.00	$750.00

STEP 4: Customer 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; 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 represent that all personal information and selections made are correct.

Customer Signature		Date	

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PARTNERS FOR HEALTH