

# Health Savings Account (HSA): Employee Enrollment and Salary Reduction Agreement

## Employee Information

Name

Last 4 digits of SSN

Address

City

State

ZIP code

( )

Daytime phone

Email

**Reason for Election** (check one):

Annual enrollment election

New employee enrollment

Qualifying life event

Effective Date: \_\_\_\_\_ (completed by employer)

## Election and salary reduction for health savings account

I authorize a salary reduction of \$\_\_\_\_\_ per year (deducted in generally equal amounts per pay) to my HSA (maximum per year of \$3,500 for self or \$7,000 for family in 2019).

## Acknowledgment, acceptance, and signature

I understand and accept the following terms and conditions:

- This authorization will be in effect for the plan year specified by the effective date. Elections for a HSA must be made on an annual basis.
- By completing and signing this form, I am authorizing my employer to withhold wages from my salary to be contributed to my HSA.
- I understand that these enrollment elections and my authorization to withhold my HSA contributions cannot be changed except during annual enrollment or upon a qualifying life event.
- I am responsible for initiating any change in my elections due to a qualifying life event, as described under the plan, within 60 days of such event. Any contributions or changed contributions must be made after the changed contribution is submitted; retroactive changes are not permitted.
- I affirm that neither I nor my spouse contributes, or will contribute, to a healthcare flexible savings account (HFSA) while enrolled and contributing to this HSA.

Employee's Signature (*required*)

Date