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 $3,600 for self or $7,200 for family in 2021).

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 an 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** _____