

Health Savings Account (HSA) Benefit Election Form

Please complete this form to elect or change your contributions to your Health Savings Account (HSA). This form is for printing and manual submission.

1. Employee Information

Employee Full Name:

Employee ID or SSN:

Date of Birth (MM/DD/YYYY):

Email Address:

2. High Deductible Health Plan (HDHP) Coverage Election

To be eligible for an HSA, you must be enrolled in a qualifying High Deductible Health Plan.

Coverage Level (Type "Individual" or "Family"):

Health Insurance Carrier Name:

3. HSA Contribution Election

Specify the amount you wish to contribute to your HSA for the plan year. Refer to current IRS limits for maximum allowable contributions.

Total Annual Election Amount (\$):

Number of Pay Periods:

Contribution Amount Per Pay Period (\$):

4. Authorization and Signature

By signing below, I authorize my employer to make pre-tax payroll deductions from my salary as indicated above and deposit these funds into my Health Savings Account.

Employee Signature (Print and Sign):

Date (MM/DD/YYYY):