Employee HSA navroll deduction form



Employee 113A payron deduction form					⊓eaii⊓ ⊑quity				
Return completed forr	ns to:								
Company name:					_				
ttn:					_				
эх:					_				
mail address:					_				
Annual emplo	yer contrib	ution info	rmation						
	Family			Other (optional)					
Self-only			ranniy		Ctrici (optional)				
For mid-year enrollee	es, contact your l	HR departmer	nt for your pro-rated	em	ployer election amou	nt.			
Notes									
			oution calculat	toı					
2017 annual HSA contribution						018 annual HSA contributions			
Coverage type	Total annual		Per month		Coverage type	Total annual contribution* Per month			
Self-only Family	. ,	400 750	\$283.33 \$562.50		Self-only Family		\$3,450 \$287.50 \$6,900 \$575.00		
*Catch-up contribution (a	. ,		φσσΞ.σσ		*Catch-up contribution (ag	e 55+): addi	,	φστοιοσ	
Total annual contribution			Total annual employer contribution			Total eligible amount			
		(MINUS)			=				
Total eligible	amount		Enter number of p	er number of pay periods remaining			Per-pay period max withholding		
		/ (DIVIDED)	in the year from form submittal date		=				
L		(BIVIBED)							
							te of your high-deducti		
, ,		, ,				,	nd you're not required to prorated amount is co	'	
excess contribution a	nd subject to a p						ty, please contact Healt		
Member Services at 8	366.346.5800.								
Employee info	rmation an	d authori	zation						
Employee name				l	Last 4 of SSN or employee ID				
Please withhold \$		from my (\	weekly/bi-weekly/mo			the fund	s to my HealthEquity H	SA.	
Signature				[Date				