

# Employee HSA Payroll Deduction Form

Return completed forms to:



Company Name: \_\_\_\_\_

Attn: \_\_\_\_\_

Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Annual Employer Contribution Information

Self-Only	Family	Other (optional)

For mid-year enrollees, contact your HR department for your pro-rated employer election amount.

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HSA Contribution Limits and Contribution Calculator

2016 Annual HSA Contributions			2017 Annual HSA Contributions		
Coverage Type	Total Annual Contribution*	Per Month	Coverage Type	Total Annual Contribution*	Per Month
Self-Only	\$3,350	\$279.16	Self-Only	\$3,400	\$283.33
Family	\$6,750	\$562.50	Family	\$6,750	\$562.50

\*Catch-up contribution (age 55+): additional \$1,000/year

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<b>Total Annual Contribution</b> _____	- (MINUS)	<b>Employer Contribution</b> _____	=	<b>Total Eligible Amount</b> _____
<b>Total Eligible Amount</b> _____	/ (DIVIDED)	<b>Enter number of pay periods remaining in the year from form submittal date</b> _____	=	<b>Per-Pay Period Max Withholding</b> _____

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your high-deductible health plan (HDHP). If you're covered as of December 1, you're considered an eligible individual for the entire year and you're not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any funding over the prorated amount is considered an excess contribution and subject to a penalty and income tax. For further information or to review eligibility, please contact HealthEquity Member Services at 866.346.5800.

## Employee Information and Authorization

Employee Name	Last 4 of SSN or Employee ID
Please withhold _____ from my (Weekly/Bi-Weekly/Monthly) payroll and apply the funds to my HealthEquity HSA.	
Signature	Date