

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

2015 Annual HSA Contributions			2016 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	\$3,350	\$279.16
Family	\$6,650	\$554.16	Family	\$6,750	\$562.50

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

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

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