

Employee HSA payroll deduction form



Return completed forms to:

Company name: Pittsylvania County

Attn: Kathy Yeatts

Fax: 434-432-7746

Email address: kathy.yeatts@pittgov.org

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

| 2019 annual HSA contributions | | |
|-------------------------------|----------------------------|-----------|
| Coverage type | Total annual contribution* | Per month |
| Self-only | \$3,500 | \$291.67 |
| Family | \$7,000 | \$583.33 |

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

| 2020 annual HSA contributions | | |
|-------------------------------|----------------------------|-----------|
| Coverage type | Total annual contribution* | Per month |
| Self-only | \$3,550 | \$295.83 |
| Family | \$7,100 | \$591.67 |

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

| | | | | |
|----------------------------------|-----------|---|---|---------------------------------------|
| Total annual contribution | - | Total annual employer contribution | = | Total eligible amount |
| 2020 Self-Only \$3,550 | (MINUS) | | | 3550 |
| Total eligible amount | / | Enter number of pay periods remaining in the year from form submittal date | = | Per-pay period max withholding |
| 3550 | (DIVIDED) | 1 | | 3,550.00 |

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 |