

Employee Information (required)

First Name:	MI:	Last Name:		
SSN#:	Date of Birth:			
Address:		City:	State:	Zip:
Daytime Phone: ()	Home phone: ()	Email:		

Health Savings Account Contribution Limits

The 2018 annual HSA contribution limit for individuals with self-only HDHP coverage is \$3,450, and the limit for individuals with family HDHP coverage is \$6,900.

I authorize my employer to make the following salary reductions:

Health Savings Account:

I elect to have \$_____ deposited annually into my Health Savings Account.

I understand that by signing this Election Form I am authorizing any necessary pre-tax deductions required to pay for above elected benefit selections.

 Employee Signature

 Date