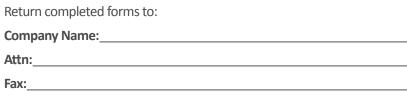
Employee HSA Payroll Deduction Form





Company Name:									
Attn:									
Email Address:									
Annual Employ	er Contrib	ution Info	ormation						
Sel		F	am	nily	Other (optional)				
For mid-year enrolle	es, contact yo	ur HR depar	tment for your p	ro-r	rated employer elec	tion amo	unt.		
Notes:									
HSA Contribution	on Limits a	nd Contri	ibution Calcu	lat	or				
2015 Annual HSA Contributions					2016	6 Annual HSA Contributions			
Coverage Type Total Annual Contribut			Per Month		Coverage Type	Total A	Total Annual Contribution* Per M		
Self-Only	\$3,3	350	\$279.16		Self-Only	\$3,350 \$279.16		\$279.16	
Family \$6,650			\$554.16 Family		Family		\$6,750 \$562.50		
*Catch-up contribution (age 55+): additio	nal \$1,000/yea	r		*Catch-up contribution	(age 55+):	additional \$1,000/year		
Total Annual Contribution		_	Employe		ontribution		Total Eligible Amount		
		(MINUS)				=			
Total Eligible Amount		/	Enter number of pay periods remaining in the year from form submittal date		=	Per-Pay Period Max Withholding			
		(DIVIDED)							
Eligibility and contribution health plan (HDHP). required to pro-rate the prorated amount review eligibility, ple	If you're cove your contribu t is considered	ered as of De tions. If you d an excess o	ecember 1, you're cease to be an el contribution and	e co ligib sub	nsidered an eligible ble individual during ject to a penalty and	individuathe next	al for the entire year calendar year, any f	and you're not unding over	
Employee Infor	mation an	d Author	ization						
Employee Name					Last 4 of SSN or Employee ID				
Please withhold		from my	v (Weeklv/Ri-Wee	klv.	/Monthly) payroll an	d apply t	he funds to my Healt	hEquity HSA.	
Signature			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Date Date	~~~	and to my modific	40.0, 110/11	