

HEALTH SAVINGS ACCOUNT REQUEST FOR CHANGE IN PARTICIPATION



Plan Year: 2019 Employer: _____
Social Security Number: XXX - XX - _____ Date of Birth: _____
First Name: _____ MI: _____ Last Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Daytime Phone: (____) _____ Date of Hire: _____
Email: _____

CHANGE IN PARTICIPATION or TERMINATION

I hereby revoke any previous authorization for the current year and authorize my employer to make the pre-tax payroll deductions, which I have indicated below. I also understand that deductions will be taken in equal amounts from each of my paychecks, but only if my pay is sufficient to cover those amounts.

HEALTH SPENDING ACCOUNT

NEW MONTHLY HSA CONTRIBUTION:

I authorize my employer to deduct \$_____ from my payroll, in equal amounts, to be placed in my Health Savings Account. *This amount should not exceed IRS allowed maximums and may include certain rollovers from other eligible accounts.*

Employee Signature: _____ Date: _____

RETURN COMPLETED FORM TO YOUR HUMAN RESOURCES DEPARTMENT

FOR EMPLOYER USE ONLY

Change Approved: Effective Date: _____ Change Denied:

Employer Signature: _____ Date: _____