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:____

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HSA Contribution Limits and Contribution Calculator

2016 Annual HSA Contributions		
Coverage Type	Total Annual Contribution*	Per Month
Self-Only	$3,350	$279.16
Family	$6,750	$562.50

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

2017 Annual HSA Contributions		
Coverage Type	Total Annual Contribution*	Per Month
Self-Only	$3,400	$283.33
Family	$6,750	$562.50

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

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