HEALTH SAVINGS ACCOUNT (HSA) BENEFIT ELECTION FORM

EMPLOYEE INFORMATION

First Name:	M.I.:	Last Name:	
Social Security Number:	Date of Birth:	Gender: ❑ Male ❑ Female	
Mailing/Street Address:	City:	State:	Zip Code:
Phone Number:	Email Address:		

2020 CONTRIBUTION LIMITS

❑ I am enrolling in self-only HDHP coverage (*$3,550 contribution limit*).
❑ I am enrolling in family HDHP coverage (*$7,100 contribution limit*).

❑ I am 55 or older (*an additional $1,000 contribution is allowed*).

AUTHORIZATION

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

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

____
Employee Signature

____
Date