

nployee HS				Health Equit y			
urn completed forr	ns to:						_90,
mpany name:							
n:				_			
: <u> </u>							
ail address:							
nnual emplo	yer contrib	ution infor	mation				
S	Self-only		Family		Other (optional)		
or mid-year enrolled otes	es, contact your	HR department	for your pro-rated e	mployer election amou	int.		
SA contribut	ion limits a	nd contrib	for your pro-rated e	or			
SA contribut	i on limits a l	nd contribu	ution calculate	or 20	024 annu	al HSA contributions	Daymanth
SA contribution 2 Coverage type	ion limits an 023 annual HSA Total annual	nd contributions	ution calculate	Coverage type	024 annu	nnual contribution*	Per month
SA contribut	ion limits and the second seco	nd contribu	ution calculate	or 20	024 annu	nnual contribution* \$4,150	Per month \$345.83 \$691.66
SA contribution 2 Coverage type Self-only	ion limits and annual HSA Total annual \$3,	contributions contribution* 850	Per month	Coverage type Self-only	024 annu Total a	\$4,150 \$8,300	\$345.83
Coverage type Self-only Family	ion limits and the second seco	contributions contribution* 850	Per month \$320.83 \$645.83	Coverage type Self-only Family	024 annu Total a	\$4,150 \$8,300	\$345.83 \$691.66
Coverage type Self-only Family Catch-up contribution (a	ion limits and the second seco	contributions contribution* 850	Per month \$320.83 \$645.83	Coverage type Self-only Family 'Catch-up contribution (ag	024 annu Total a	\$4,150 \$8,300 tional \$1,000/year	\$345.83 \$691.66

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/mor	from my (weekly/bi-weekly/monthly) payroll and apply the funds to my HealthEquity HSA.					
Signature	Date					