EMPLOYEE HEALTH SAVINGS ACCOUNT (HSA) PAYROLL DEDUCTION FORM 2018

HARTLAND CONSOLIDATED SCHOOLS

PLAN YEAR RUNS JAN 1 THRU DEC 31, 2018

~ HSA ONLY AVAILABLE TO EMPLOYEES WITH MESSA ABC PLAN
~ YOU CANNOT ENROLL IN AN HSA PLAN IF:
~ YOU ARE ENROLLED IN MEDICARE
~ YOU ARE ENROLLED IN FSA MEDICAL PLAN IN SAME CALENDAR YEAR

Return completed form to:
Michele Matusik, Payroll Dept.
Scan to email or interschool mail ONLY
michelematusik@hartlandschools.us

Please mark appropriate box:

OPEN ENROLLMENT ☐ (Change will be effective January 1, 2018

NEW ELECTION ☐

CHANGE ELECTION ☐

* "New Election" or "Change" will be effective the first pay day of the month following date received

HSA Contribution Limits and Contribution Information/Examples

2018 Annual HSA Contributions Maximum Info.	
Coverage Type	Total Annual Contribution Max ~
Single	$3,450
2 Person/Full Family	$6,850

~ Catch-up contribution (age 55+): additional $1000/year

Total Annual Amt. Elected		Number of pay periods from Jan-Dec 2018 (20) or remaining # *	Per Pay Withholding Amt. Elected*
$	/ (Divided By)		$
		*Note: 20 total deductions if all pay periods Jan-June 2018 (12 pays) & Sept-Dec 2018 (8 pays) No deductions in July or Aug.	*Call or email Michele Matusik (x-2126) for assistance with # of pays remaining if enrolling late for 2018 calendar year (after 1/12/18 payroll)

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 is subject to a penalty and income tax. For further information or to review eligibility, please contact HealthEquity Member Services at 1-866-346-5800.

Employee Information and Authorization

Employee Name (Please Print):		Full SSN or Employee ID (**Required**):
Please Withhold * (Same as amt. above):	$	from my bi-weekly payroll, twice monthly, & apply the funds to my HealthEquity HSA.
I authorize payroll deduction in connection with my election amount above. I understand the benefit options that I have elected will remain in force throughout the plan year.		
Employee Signature		Date

For further general HSA Info:
HealthEquity®
Building Health Savings
1-866-346-5800
www.healthequity.com

For Payroll Office Use Only:

Entered in System (Initial and Date):

Submitted to HE (Initial and Date):