

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

HSA contribution limits and contribution calculator

| 2024 annual HSA contributions | | | 2025 annual HSA contributions | | |
|-------------------------------|----------------------------|-----------|-------------------------------|----------------------------|-----------|
| Coverage type | Total annual contribution* | Per month | Coverage type | Total annual contribution* | Per month |
| Self-only | \$4,150 | \$345.83 | Self-only | \$4,300 | \$358.33 |
| Family | \$8,300 | \$691.66 | Family | \$8,550 | \$712.50 |

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

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| | | | | |
|----------------------------------|----------------|---|---|---------------------------------------|
| Total annual contribution | - (MINUS) | Total annual employer contribution | = | Total eligible amount |
| <input type="text"/> | | <input type="text"/> | | <input type="text"/> |
| Total eligible amount | / (DIVIDED) | Enter number of pay periods remaining in the year from form submittal date | = | Per-pay period max withholding |
| <input type="text"/> | | <input type="text"/> | | <input type="text"/> |

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 |