Health Savings Account (HSA) Enrollment Form

Name: _____
Last First M.I.

SSN: _____ DOB: _____

Address: _____

Home Phone: _____ Department: _____

Employee ID: _____

☐ I elect to enroll in a Health Savings Account (HSA). I understand the County contributes $1,000 and will match 50% of my contribution up to $30 per pay period to my HSA. Please select one of the following:

- ☐ I elect to contribute _____ per pay period to a HSA **Employee Only** HSA, or:
- ☐ I elect to contribute _____ per pay period to a HSA **Dual/Family** HSA

☐ I am not an eligible individual and do not qualify for an HSA because I do not meet one of the following requirements:

- ☐ I have other health coverage that is not permitted under IRS regulations.
- ☐ I am enrolled in Medicare.
- ☐ I can be claimed as a dependent on someone else's federal tax return.

_____ _____
Employee Signature Date

HR Use Only:

Effective Date: _____ = _____ Pay Periods

Per Pay Contribution	**Deduction Limit** (Per Pay Contribution times Pay Periods)	**Deduction Balance** (Same as Deduction Limit)