HEALTH SAVINGS ACCOUNT 2019-20

PAYROLL CONTRIBUTION ELECTION FORM

☐**New Enrollment**
☐**Change/Delete Amount**

Name: Last, First, Middle Initial		Payroll Person Code #
Street Address		DOB
City	State	Zip Code
Department	Home or Cell Phone #	Work Phone Ext. #

The IRS has established annual limits* that can be contributed to a Health Savings Account for calendar year **2020** of **$3,550** for single coverage and **$7,100** for family coverage (2019 limits are $3,500/$7,000) provided your health plan is a qualifying HDHP. **The annual account limits include the County contribution of $330 per QUARTER for full-time employees and $165 per QUARTER for Eligible Part-Time Employees.**

The law allows you to make a full year's contribution into your HSA. However, if you make a full-year HSA contribution as a mid-year HDHP enrollee, you must continue to be an HSA-eligible individual and maintain HDHP coverage during the 13-month period beginning with the last month of that calendar year and ending at the end of the following calendar year. If you fail to maintain HSA eligibility for the required 13 months (for reasons other than death or disability), a portion of your contributions will become subject to income tax and a 20–percent additional tax penalty.

> *In other words, if you make a contribution for months before you were HSA-eligible, you will need to remain covered by the HDHP/HSA through the last month of the following calendar year to avoid taxes and penalties.*

Finally, catch up contributions are allowed for individuals who are age 55 or who turn age 55 during the calendar year and older. Catch up contributions are limited to a maximum of $1,000 per year.

* **NOTE**: Since your contribution limits are specific to your circumstances, we recommend that you contact your Tax Advisor to verify what your contribution limits are.

Health Savings Account (HSA) Employee Contribution. Enter the amount that you would like deducted from your payroll and deposited into your Health Savings Account.

Per Pay Period Amount $_______________ **Deduction to begin:** ____/_____/_____

Please read, sign and date this form:

I authorize the pre-tax reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that any withdrawals/distributions made from my HSA for health care expenses incurred prior to the establishment of my HSA or for other non-qualified types of expenses will be **taxable** and may be subject to additional penalties in accordance with IRS regulations. I further understand that it is solely my responsibility to report these withdrawals/distributions to the IRS.

Signature Date

rev. 8/2/2019 kej