HA-0914-0220

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM

1. MEMBER INFORMATION

Member Name_____
Last First Middle Initial

Social Security Number_____ Location Number _____ Date _____/_____/_____

2. PAYROLL REQUEST

☐ I authorize my employer to deduct the Health Savings Account (HSA) contribution identified below on a pre-tax basis beginning no earlier than the date my HSA medical plan will become effective. The funds are eligible to be deposited into my Health Savings Account.

Contributions are subject to federal limits. Annual limits for 2020: $3,500 for individuals; $7,000 for families. Additional allowable contributions for individuals between the ages of 55-65: $1,000 for the account holder only. Contributions will begin after your HSA bank account has been opened with the banking institution selected by your provider.

Note: Employer contributions to your HSA count toward the annual limit.

Please fill in the desired amount below.

Deduct $ _____ per pay.

☐ Cancel deductions for the Health Savings Account from my paycheck.

3. HEALTH PLAN

High Deductible Health Plan (HDHP) (Check one)

☐ NJ DIRECT HD4000* ☐ NJ DIRECT HD1500

Note: *SEHBP Plan members are not eligible to select NJ DIRECT HD4000.*

Coverage Level (Check one)

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Family ☐ Member and Domestic Partner

☐ Parent and Child(ren)

Member Signature_____ Date _____/_____/_____

Please return the completed form with your enrollment application to your benefits administrator

BENEFITS ADMINISTRATORS: RETAIN THIS FORM FOR YOUR FILES