2021 Health Savings Account Change Form

Change Deadline: Last day of the month

All changes will take effect the following month

Last Name: _____ **Dept/Loc:** _____

First Name: _____ **Phone No:** _____

SSN Number: _____

Signature: _____ **Date:** _____

Employee Contribution Limits
Employee: $3,600 **Family: $7,200** Additional $1,000 catch up contribution allowed if employee is 55 years or over.

District Contribution Limits		
	Direct Contribution: divided by 24 pays	**$ for $ District Match:**
Employee:	$400 = $16.67	$400
Employee +1:	$600 = $25.00	$600
Family:	$800 = $33.34	$800

Please indicate the *MONTHLY amount you would like to contribute beginning with the current month, leave previous months blank. We cannot make retro-active changes.

***Amount entered will be split evenly between the two pay periods.**

Month	Employee Amount
January	$
February	$
March	$
April	$
May	$
June	$

Month	Employee Amount
July	$
August	$
September	$
October	$
November	$
December	$