



Health Savings Account (HSA) Contribution Options & Salary Reduction Arrangement

By my signature below, I certify that I have enrolled, or plan to enroll, in an HSA-compatible health plan and that I am not covered under any other plan that would disqualify me from opening or contributing to my HSA. I understand that this form is provided for convenience purposes and that HSA Bank will not initiate contributions to my HSA, but will allow my employer or their authorized agent to initiate contributions to my account.

OPTION ONE

☐ I elect to contribute to my HSA with a pre-tax salary reduction through my employer's Section 125 Cafeteria Plan, and authorize my employer to deduct the amounts as indicated from my salary and forward the funds to HSA Bank to deposit in my HSA.

Deduction Option:

- ☐ \$ 50.00 per pay period
\$ 75.00 per pay period
☐ \$ 100.00 per pay period
☐ Maximum Single Contribution \$4,150 (less employer contribution/age =>55 add \$1000)
☐ Maximum Family Contribution \$8300 (less employer contribution/age =>55 add \$1000)
☐ Other \$ ____.

Total Annual Employee Contribution: \$ ____.

Total Annual Employer Contribution (if applicable): \$ ____.

Note: Your Total Annual Employee Election along with contributions from any other sources, including your employer, may not exceed the Annual Maximum Contribution amount set by the IRS. Contribution limits can be found at: www.hsabank.com or by visiting the IRS site at: www.irs.gov.

Date of first HSA contribution: ____ / ____ / ____

(Date must be on or after the first day of your HSA-compatible health plan coverage or the first day of opening your HSA, whichever is later. Leaving the date blank will authorize your employer to determine the date on your behalf.)

OPTION TWO

☐ I do not want to contribute to my HSA through a pre-tax salary reduction. I understand that I can make after-tax contributions to my HSA online - through Internet Banking (<https://secure.hsabank.com/ibanking/>), or by mailing a check with a contribution form.

Employee Name: _____ SSN: ____ / ____ / ____

Employee Address: _____

(City)

(State)

(Zip Code)

Employee Signature: _____ Date: ____ / ____ / ____

Please return this form to your employer.