Blue Cross Blue Shield of Rhode Island

Please Send Completed Form To Jordan Votto at Admin. Bldg. or jordan_votto@ewg.k12.ri. us

Health Savings Account

2024 Employee Contribution Authorization Form

Employee Information:

First Name:	Last Name:	
Street Address:		
City:	State:	Zip Code:
Date of Birth:	Social Security#:	

You are responsible for the first $6,000(family) $3,000 (individual) of medical costs
On January 1, 2024 the District will make the following contribution to your HSA account:
Certified: Family = $2,000 Individual = $1,000
Non-Certified: Family = $2,750. Individual = $1,375.
To fully fund your Annual Deductible, contributions are as follows:
Certified Family $4,000 Certified Individual $2,000
Non-Certified Family $3,250 Non-Certified Individual $1,625

The MAXIMUM amount per the IRS that an employee may contribute is as follows: **Certified Family $6,300 Certified Individual $3,150**
Non-Certified Family $5,550 Non-Certified Individual $2,775

Employee HSA Contribution: $_____Divided by # of Payrolls_____Per Payroll Amount $_____

Additional Debit Card Request: (only complete this section for tax-dependents to be issued debit cards)

Dependent Name:	SS#:	Date of Birth:
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I Understand That:

(1) I agree to have my compensation reduced by the deduction amount(s) stated above. I further understand that the Health Savings Account deduction will be in effect until *my* participation in the HSA is terminated and I may make changes at any time to *my* HSA contribution.

(2) By signing this form. I confirm all information stated is true and correct.

Employee Signature: _____ Date: _____