HEALTH SAVINGS ACCOUNT (HSA) – Compensation Reduction Agreement

(Additional Pre-tax Account Contribution through Payroll Deduction)

Name: _____ Social Security #: _____

Address: _____

HSA Checking Account #: _____

I have enrolled for certain benefits under the:

___ **Health Savings Account (HSA)** – offered to those with the Cigna HSA Health Insurance Plan. An additional pre-tax account contribution through payroll deduction

- I elect to receive the benefits provided to me under the HSA by reducing my compensation by **$_____** dollars per pay period (minimum of $20), but in no event shall my total compensation reduction for the year exceed the maximum total contribution amount permitted by me **and** my employer (maximum $4,150 for individual or $8,300 for family for 2024, **which includes contributions made by my employer**). Individuals age 55 and older may contribute an additional $1,000.
- To be effective on the payroll date _____ (date).

I understand that:

- My employer and I agree that my compensation will be reduced, subject to the maximum contribution amount set forth above, and shall continue for each succeeding pay period until this agreement is changed or revoked, or until I reach my maximum contribution amount as set for above.
- I may change (increase or decrease) the amount of my payroll reduction or revoke this benefit election in the open enrollment period prior to April 1st of each year, and am encouraged to limit additional changes to once each year. In addition, I may change or revoke this benefit election or Compensation Reduction Agreement as of any date prior to the next April 1st, if I terminate my employment with my employer, or I have a "major life event" (i.e. marriage or divorce of employee, death of a spouse or dependent of employee, birth or adoption of a child by employee, termination or commencement of employment of a spouse, switching from part-time to full-time or from full-time to part-time employment status by employee or spouse, taking an unpaid leave of absence by the employee or spouse, and any event which the Plan administrator deems to be a change in the family status of the participant).
- The Plan Administrator may reduce or cancel the amount of my compensation reduction or otherwise modify this Compensation Reduction Agreement in accordance with the provisions of the Health Savings Account Plan if it believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this Compensation Reduction Agreement will be in addition to any reductions under other agreements or benefit plans.
- This benefit election will automatically be canceled as of the date of my termination of employment.
- I certify the above information to be correct and true to the best of my knowledge.

_____ _____

Signature of Employee Date

Accepted and agreed to:

_____ _____

Signature for Employer Date

Title: _____

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