HSA CONTRIBUTION REQUEST - 2019

Name:____________________________________ **Employee ID Number:**____________

Health Savings Account Number: ____________________________________

My employer and I hereby agree that my cash compensation will be reduced as outlined below and will be taken from my pay in the number of equal installments I have indicated.

Health Savings Account Contribution:
(Note: Do not include premium contributions or District contribution in this amount.)
Total amount Desired to Fund Health Savings Account
(Maximum Annual Election $7,000 for Family Coverage and $3,500 for Single Coverage. Age 55 and over can elect an additional $1,000 per calendar year.)

Pay Period Election:

Pay Periods:

◯ Check here if this is a change to a prior election

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This agreement is subject to the terms of the Community Unit School district Health Savings Account Plan (as may be amended) and revokes any prior election and compensation reductions agreement relating to these options of the Plan.

____ ____________________
Employee Signature Date

Send this form to Katie.Lind@d300.org