HA-0914-0916

STATE OF NEW JERSEY
DIVISION OF PENSIONS AND BENEFITS
STATE HEALTH BENEFITS PROGRAM

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM

EMPLOYEE INFORMATION

Employee Name: _____
Last First Middle Initial

Social Security Number: _____ Location Number: _____ Date:_____

PAYROLL REQUEST

☐ I authorize my employer to deduct the Health Savings Account (HSA) contributions identified below on a pre-tax basis beginning no earlier than the date my HSA medical plan will become effective. The funds are eligible to be deposited into my Health Savings Account.

Contributions are subject to federal limits. Annual limits for 2017: $3,400 for individuals; $6,750 for families. Note: Employer contributions to your HSA count toward the annual limit.

Additional allowable contributions for individuals between the ages of 55 - 65: $1,000 for the account holder only.

Please fill in the desired amount below.

Per Pay: _____

Contributions will begin after your HSA bank account has been opened with the banking institution selected by your provider.

☐ Cancel deductions for the Health Savings Account from my paycheck.

HEALTH PLAN

High Deductible Health Plan (HDHP) (Choose one from below)

☐ NJ DIRECT HD4000*
☐ NJ DIRECT HD1500
☐ Aetna Value HD4000*
☐ Aetna Value HD1500

Coverage Level (Choose one from below)

☐ Single
☐ Member and Domestic Partner
☐ Parent and Child(ren)
☐ Member and Spouse/Civil Union Partner
☐ Family

Employee Signature: _____ Date:_____

Please return the completed form with your enrollment application to your benefits administrator.

BENEFITS ADMINISTRATORS: RETAIN THIS FORM FOR YOUR FILES