



State of New Jersey • Division of Pensions &amp; Benefits (NJDPB)

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

**HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM****EMPLOYEE INFORMATION**Employee Name: \_\_\_\_\_  
*Last*
*First*
*Middle Initial*

Social Security #: \_\_\_\_\_ Location #: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PAYROLL REQUEST**

- I authorize my employer to deduct the Health Savings Account (HSA) contribution 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 2018: \$3,450 for individuals; \$6,900 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)

- |  |  |
|--|--|
| <input type="checkbox"/> NJ DIRECT HD4000* | <input type="checkbox"/> Aetna Value HD4000* |
| <input type="checkbox"/> NJ DIRECT HD1500  | <input type="checkbox"/> Aetna Value HD1500  |

\*School Employees' Health Benefits Plan members are not eligible to select NJ DIRECT HD4000 or Aetna Value HD4000.

**Coverage Level** (Choose one from below)

- |  |  |
|--|--|
| <input type="checkbox"/> Single                | <input type="checkbox"/> Member and Spouse/Civil Union Partner |
| <input type="checkbox"/> Family                | <input type="checkbox"/> Member and Domestic Partner           |
| <input type="checkbox"/> Parent and Child(ren) |  |

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**BENEFITS ADMINISTRATORS: RETAIN THIS FORM FOR YOUR FILES**