



State Health Benefits Program (SHBP)

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM

For State Centralized Payroll Employees

MEMBER INFORMATION

Member Name _____
Last First Middle Initial

Social Security Number _____ Payroll Number _____ Date ____/____/____

PAYROLL REQUEST — Choose one

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 2021: \$3,600 for individuals; \$7,200 for families. Additional allowable contributions for individuals between the ages of 55-65: \$1,000 for the account holder only. Contributions will begin after your HSA bank account has been opened with the banking institution selected by you provider.

Note: Employer contributions to your HSA count toward the annual limit.

Please fill in the desired amount below.

Deduct \$ _____ per pay period.

Cancel deductions for the Health Savings Account from my paycheck.

HEALTH PLAN

High Deductible Health Plan (HDHP) (Check one)

NJ DIRECT HD1500 NJ DIRECT HD4000

Coverage Level (Check one)

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

Member Signature *Date*

Please return the completed form to: N.J. Department of the Treasury
OMB – Centralized Payroll
P.O. Box 207
33 West State Street, 2nd Floor
Trenton, NJ 08625-0207