HA-0914-1020

State Health Benefits Program (SHBP)

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM

MEMBER INFORMATION

Member Name____
Last *First* *Middle Initial*

Social Security Number______________________ Location 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 your provider.

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

Please fill in the desired amount below.

Deduct $ _________________________ per pay.

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

HEALTH PLAN

High Deductible Health Plan (HDHP) (Check one)

☐ NJ DIRECT HD4000 ☐ NJ DIRECT HD1500

Coverage Level (Check one)

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

____ _____/_____/_____
Member Signature *Date*

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

BENEFITS ADMINISTRATORS: RETAIN THIS FORM FOR YOUR FILES