HEALTH SAVINGS ACCOUNT
2019 EMPLOYEE CONTRIBUTION ELECTION FORM

Employer Name: Jackson County Central Schools

ACCOUNT OWNER'S NAME AND ADDRESS

_____

Last Name **First Name** **Middle Initial**

_____

Street Address

_____

City **State** **Zip Code**

_____

Social Security No. **Birthdate** **Employee #**

AGE 55+ CONTRIBUTION ATTESTATION

☐ I am over the age of 55 AND I elect to utilize my HSA "catch up" contribution rights as necessary.

CONTRIBUTIONS

☐ **2019 Enrollment:** I wish to contribute $_____to my HSA account each pay period, on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise.

SIGNATURE

It is my responsibility 1) to determine whether I am eligible to make contributions to my HSA; And 2) to determine whether contributions to this HSA have exceeded the applicable maximum annual contribution limit. I understand that providing false information or omission of relevant information in this form may result in the delay or denial of this change

I authorize applicable payroll deduction(s) to be withheld from my paycheck beginning on: 1/15/2019

_____ _____

Account Owner Signature Signature Date