



**Employee Information (required)**

First Name:	MI:	Last Name:		
SSN#:	Date of Birth:			
Address:		City:	State:	Zip:
Daytime Phone: (    )	Home phone: (    )	Email:		

**Health Savings Account Contribution Limits**

The 2018 annual HSA contribution limit for individuals with self-only HDHP coverage is \$3,450, and the limit for individuals with family HDHP coverage is \$6,900.

**I authorize my employer to make the following salary reductions:**

**Health Savings Account:**

I elect to have \$\_\_\_\_\_ deposited annually into my Health Savings Account.

I understand that by signing this Election Form I am authorizing any necessary pre-tax deductions required to pay for above elected benefit selections.

\_\_\_\_\_  
 Employee Signature

\_\_\_\_\_  
 Date