



**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