HA-0913-1023

State Health Benefits Program (SHBP)

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM

For State and Local Government Employees

MEMBER INFORMATION

Member Name_____
Last *First* *Middle Initial*

Social Security Number_____ Location/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 2024: $4,150 for individuals; $8,300 for families. Additional allowable contributions for individuals age 55 or older: $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 period (State biweekly employees) ☐ month (State monthly and local government employees)

☐ I am age 55 or older and wish to contribute an additional $1,000 per year.

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

HEALTH PLAN

High Deductible Health Plan (HDHP) (Check one)

☐ NJ DIRECT HDLow ☐ NJ DIRECT HDHigh

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 this completed form to your Human Resources department.