

Employee HSA payroll deduction form



Return completed forms to:

Company name: Lakewood Public Schools

Attn: Vicki Nucich

Fax: (616) 374-8858

Email address: vickinucich@lakewoodps.org

| Annual employer contribution information | | |
|--|--------|------------------|
| Self-only | Family | Other (optional) |
| | | |

For mid-year enrollees, contact your HR department for your pro-rated employer election amount.

Notes

HSA contribution limits and contribution calculator

| 2023 annual HSA contributions | | | 2024 annual HSA contributions | | |
|-------------------------------|----------------------------|-----------|-------------------------------|----------------------------|-----------|
| Coverage type | Total annual contribution* | Per month | Coverage type | Total annual contribution* | Per month |
| Self-only | \$3,850 | \$320.83 | Self-only | \$4,150 | \$345.83 |
| Family | \$7,750 | \$645.83 | Family | \$8,300 | \$691.66 |

*Catch-up contribution (age 55+): additional \$1,000/year

| | | | | |
|-------------------------------------|-----------|---|---|---------------------------------------|
| Total annual contribution | - | Total annual employer contribution | = | Total eligible amount |
| 2024 Family \$8,300 + \$1,000 catch | (MINUS) | | = | 9,300 |
| Total eligible amount | / | Enter number of pay periods remaining in the year from form submittal date | = | Per-pay period max withholding |
| 9,300 | (DIVIDED) | 1 | = | 9,300.00 |

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your high-deductible health plan (HDHP). If you're covered as of December 1, you're considered an eligible individual for the entire year and you're not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any funding over the prorated amount is considered an excess contribution and subject to a penalty and income tax. For further information or to review eligibility, please contact HealthEquity Member Services at 866.346.5800.

Employee information and authorization

| | |
|---|------------------------------|
| Employee name | Last 4 of SSN or employee ID |
| Please withhold \$ _____ from my (weekly/bi-weekly/monthly) payroll and apply the funds to my HealthEquity HSA. | |
| Signature | Date |