



HEALTH SAVINGS ACCOUNT
ADDITIONAL VOLUNTARY EMPLOYEE CONTRIBUTIONS
AUTHORIZATION FORM

Annual HSA Additional Amount	# of Payrolls left in Calendar year	Per Payroll Amount
\$		\$

HSA Account Information:

HSA Bank Name: _____

HSA Account Number: _____

ABA (Routing) Number: _____

I understand that:

- 1) I agree to have my compensation reduced by the deduction amount(s) stated above. I further understand that the Health Savings Account deduction will be in effect until my participation in the HSA is terminated and I may make changes at any time to my HSA contribution.
- 2) **The maximum IRS contribution limits for the calendar year 2021 are \$3,600 for individual coverage and \$7,200 for family coverage.** Accordingly, this form will be in full effect until December 31, 2021.
- 3) This deduction will be deposited to my HSA account via direct deposit.
- 4) I am responsible for monitoring my contribution limits.
- 5) This change will be effective the following payroll after the authorization has been submitted.
- 6) By signing this form, I confirm all information stated is true and correct.

Name (print)

Signature

Date