Health Savings Account
CHANGE FORM

Purpose: After a Health Savings Account (HSA) is open and established, use this form:
- To change current payroll deduction amounts for HSA contributions;
- To elect new "Employee" Plan Year payroll deductions for HSA contributions

This form should be submitted to the Office of Human Resources, 301 Howell McDowell

EMPLOYER:

EFFECTIVE DATE OF HSA ELECTION: / /

A. EMPLOYEE INFORMATION

MSU ID: Social Security Number:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / /

Email Address: _____

B. HSA PAYROLL CONTRIBUTION ELECTION ***Please enter your HSA election.***

Contribution Recommendations
- Fund to Deductible (Deductible – Employer Contributions)
- Fund to Maximum out-of-pocket (Max OOP – ER Contributions)
- Fund to Contribution Limit (Contribution Limit – ER Contributions)

I authorize my employer to initiate the following payroll deduction to my HSA as follows.

Employee Per Pay Deduction: $_____

Employee Plan Year Election: $ _____

Effective Date: _____

IRS Contribution Limits

For 2022: Single Coverage: $3,650; Family Coverage: $7,300
Additional Catch-up Contribution (for those 55 and older): $1,000

The combination of employee, employer and any third party contributions may not exceed this limit.

C. EMPLOYEE CERTIFICATION ***Please return completed form to Human Resournces, 301 Howell McDowell***

- I understand the eligibility requirements for contributions made to my Health Savings Account and state that I qualify to make contributions to this account.
- I assume complete responsibility for:
  - Determining my eligibility for an HSA each year a contribution is made.
  - Ensuring all contributions made to my account are within the limits set forth by the tax laws.
  - Any tax consequences of contributions (including rollover contributions) and distributions.
- I authorize Morehead State University, my employer and/or their third party service providers to exchange information about my identity, enrollment elections, status and other information necessary to facilitate direct deposits to my HSA and to accomplish other purposes related to the payment of healthcare expenses.

Signature: _____ Date: _____/_____/_____