State of New Jersey • Division of Pensions & Benefits (NJDPB)
State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM

EMPLOYEE INFORMATION

Employee Name:_____
Last *First* *Middle Initial*

Social Security Number:_____ Location Number: _____ Date: _____/_____/_____

PAYROLL REQUEST

☐ 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 2020: $3,550 for individuals; $7,100 for families.

Note: Employer contributions to your HSA count toward the annual limit.

Additional allowable contributions for individuals between the ages of 55 - 65: $1,000 for the account holder only.

Please fill in the desired amount below.

Per Pay: _____

Contributions will begin after your HSA bank account has been opened with the banking institution selected by your provider.

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

HEALTH PLAN

High Deductible Health Plan (HDHP) Check one box only.

☐ NJ DIRECT HD4000* ☐ NJ DIRECT HD1500

**SEHBP Plan members are not eligible to select NJ DIRECT HD4000.*

Coverage Level Check one box only.

☐ Single
☐ Family
☐ Parent and Child(ren)
☐ Member and Spouse/Civil Union Partner
☐ Member and Domestic Partner

Employee Signature:_____ **Date:** _____/_____/_____

Please return the completed form with your enrollment application to your benefits administrator

BENEFITS ADMINISTRATORS: RETAIN THIS FORM FOR YOUR FILES