



School District of Menomonee Falls

MENOMONEE FALLS, WISCONSIN 53051

HEALTH SAVINGS ACCOUNT PAYROLL DEDUCTION FORM

Name: Last, First, Middle Initial

Social Security Number

Street Address

DOB

City

State

Zip Code

The IRS has established annual limits that can be contributed to a Health Savings Account.

* **NOTE:** Since your contribution limits are specific to your circumstances, we recommend that you contact your Tax Advisor to verify what your contribution limits are.

Based on your estimates, elect the amount you wish to contribute to your **Health Savings Account**.

Per Pay Period Amount \$_____ (if you wish to stop deductions, enter \$0)

Annual Amount \$_____

Please make the changes indicated above effective: _____

Please read, sign and date this form:

I authorize the reduction of my salary on a per paycheck basis, by the amount designated above.

I understand that in order for deductions to be made, I must provide the District with confirmation of a health savings account established in my name, to include the Bank Name, Routing Number and Account Number.

I understand that funds deducted from my pay and contributed to a health savings account that are not used for eligible health care expenses incurred after my HSA account was established will be **taxable** in accordance with IRS regulations, and it is solely my responsibility to report these funds to the IRS.

Signature

Date