

Step 1: Consumer Information

*=Required Fields

* Consumer Name (First, MI, Last)

*Address *City *State *Zip Code

- -

*Social Security Number *Birth Date (MM/DD/YYYY)

- -

*Day Telephone *Hire Date *Employee ID

* Email Address

Step 2: High Deductible Health Plan (HDHP) Coverage Level

There may be tax consequences if HSA contributions exceed the IRS governed limit.

*HDHP Coverage Level: Single Family

*HDHP Coverage Date

Step 3: Contribution Information

I elect an annual contribution of \$_____ for calendar year _____. See table below for guidance. The annual amount elected will be divided equally among your payroll periods. The table below shows examples of the amount you would need to contribute each payroll period in order to reach various annual contribution amounts.

Annual Contribution	Payroll Withholding				
	Weekly	Bi-Weekly	Semi-Monthly	Monthly	
\$500.00	\$9.62	\$19.23	\$20.83	\$41.67	
\$1,000.00	\$19.23	\$38.46	\$41.67	\$83.33	
\$1,500.00	\$28.85	\$57.69	\$62.50	\$125.00	
\$2,000.00	\$38.46	\$76.92	\$83.33	\$166.67	
\$2,500.00	\$48.08	\$96.15	\$104.17	\$208.33	
\$3,250.00	\$62.50	\$125.00	\$135.42	\$270.83	
2014 Single Maximum	\$3,300.00	\$63.46	\$126.92	\$137.50	\$275.00
	\$3,500.00	\$67.31	\$134.62	\$145.83	\$291.67
	\$4,000.00	\$76.92	\$153.85	\$166.67	\$333.33
	\$4,500.00	\$86.54	\$173.08	\$187.50	\$375.00
	\$5,000.00	\$96.15	\$192.31	\$208.33	\$416.67
	\$5,500.00	\$105.77	\$211.54	\$229.17	\$458.33
	\$6,450.00	\$124.04	\$248.08	\$268.75	\$537.50
2014 Family Maximum	\$6,550.00	\$125.96	\$251.92	\$272.91	\$545.83

Step 4: Consumer Authorization

By signing this application I represent that: 1) I am covered under a high deductible health plan (HDHP); 2) I am not covered by any other health plan that is not an HDHP; 3) I am not enrolled in Medicare; 4) I cannot be claimed as a dependent on another person's tax return. I understand that if my spouse is enrolled in a general-purpose FSA (a non-HDHP) I am not eligible to contribute to an HSA. I understand that my HSA cannot be effective prior to my HDHP coverage date. 5.) I authorize my employer to deduct the elected amount from my pay on each pay date. I hereby consent that all personal information and selections made are correct.

*Consumer Signature Date