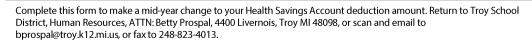
## **Health Savings Account (HSA) Contribution Action Request Form**





Employee Information Employee Name:	Emp. ID No:
Medical Coverage (check one):  ☐ Employee ☐ Family Pay Cycl *Family coverage includes Employee w/ Spouse, Employee w/ Child(ren), and Family HDHP coverage levels	le: □ 21- Week □ 26-Week
Contribution Information You may not reduce your annual amount below what you have contributed to must be an amount between the minimum and maximum as described below Maximum Contributions annual contribution (Under HSA Maximum Limits  • Employee-only HSA	v.
2017 HDHP Maximum Expenses  • Employee-only HDHP Out-of-Pocket Amount  • Family HDHP* Out-of-Pocket Amount*Family coverage includes Employee w/Spouse, Employee w/Child(ren), and Family Coverage includes Employee w/Spouse, Employee w	\$13,100
Action Request  *Please Note: A new Action Form must be completed each time an HSA deduction change is requested.	
START Existing Health Savings Account Contribution Change Effective Date:	ns (Please select one of the following):
☐ Start 2017 contributions to an existing HSA in my name a	and set my ANNUAL contribution pledge at
\$	_ Annual \$ Per Pay
CHANGE Health Savings Account Contributions Change Effective Date:	
Current 2017 HSA Annual Contribution	\$ Annual \$ Per Pay
☐ Enter your updated 2017 ANNUAL contribution pledge a	t \$ Annual \$ Per Pay
STOP Health Savings Account Contributions (Please se	
<b>Employee Authorization</b> I authorize TSD to withhold my contributions for this plan from my poto deduct will reduce my annual taxable wages.	ay on a pre-tax basis. The amount that I am requesting
CICNATIDE	DATE: