

## Employee HSA payroll deduction form



Return completed forms to:

Company name: \_\_\_\_\_

Attn: \_\_\_\_\_

Fax: \_\_\_\_\_

Email address: \_\_\_\_\_

### Annual employer contribution information

| Self-only | Family | Other (optional) |
|-----------|--------|------------------|
|           |        |                  |

For mid-year enrollees, contact your HR department for your pro-rated employer election amount.

Notes

### HSA contribution limits and contribution calculator

| 2026 annual HSA contributions |                            |           | 2027 annual HSA contributions |                            |           |
|-------------------------------|----------------------------|-----------|-------------------------------|----------------------------|-----------|
| Coverage type                 | Total annual contribution* | Per month | Coverage type                 | Total annual contribution* | Per month |
| Self-only                     | \$4,400                    | \$366.66  | Self-only                     | \$4,500                    | \$375.00  |
| Family                        | \$8,750                    | \$729.16  | Family                        | \$9,000                    | \$750.00  |

\*Catch-up contribution (age 55+): additional \$1,000/year

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|                                  |           |                                                                                   |   |                                       |
|----------------------------------|-----------|-----------------------------------------------------------------------------------|---|---------------------------------------|
| <b>Total annual contribution</b> | -         | <b>Total annual employer contribution</b>                                         | = | <b>Total eligible amount</b>          |
| 2027 Self-Only \$4,500           | (MINUS)   |                                                                                   |   | 4,500                                 |
| <b>Total eligible amount</b>     | /         | <b>Enter number of pay periods remaining in the year from form submittal date</b> | = | <b>Per-pay period max withholding</b> |
| 4,500                            | (DIVIDED) | 1                                                                                 |   | 4,500.00                              |

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your high-deductible health plan (HDHP). If you're covered as of December 1, you're considered an eligible individual for the entire year and you're not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any funding over the prorated amount is considered an excess contribution and subject to a penalty and must be reported as income tax. For further information or to review eligibility, please contact HealthEquity

Member Services at 866.346.5800.

### Employee information and authorization

|                                                                                                                 |                              |
|-----------------------------------------------------------------------------------------------------------------|------------------------------|
| Employee name                                                                                                   | Last 4 of SSN or employee ID |
| Please withhold \$ _____ from my (weekly/bi-weekly/monthly) payroll and apply the funds to my HealthEquity HSA. |                              |
| Signature                                                                                                       | Date                         |