**Ellington Board of Education**

**Health Savings Account (HSA)**

**2019 Payroll Deduction Form**

**EESS, CSEA, AFSCME, HEALTH STAFF ELECTION FORM**

**10 MONTH EMPLOYEES**

Please complete the employee information below and sign this form authorizing ***or*** refusing the **optional pre-tax** payroll deduction. The payroll deduction you authorize will be directly deposited into your Health Savings Account (HSA) during the plan year. **This form must be signed and submitted to the Business Office.**

**Employee Information**:

**Name S.S. # (last 4 digits) Date of Birth**

**Address**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School Home Phone #**

**\_\_\_\_\_\_\_\_\_\_\_\_\_Employee Refusal:** I **DO NOT** wish to have any optional pre-tax dollars taken from my bi-weekly pay and deposited into my HSA plan at this time.

\_\_\_\_\_\_\_\_\_\_\_\_\_**Employee Authorization**: I **AUTHORIZE** the following pre-tax dollars to be deducted from my bi-weekly pay and deposited into my HSA account.

**H.S.A. Employee Bi-Weekly Deduction (19 times) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_**

**Total Deduction per School Year (Bi-weekly amount above x 19) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\*\**Total 2019 Contribution Limits of:***

 ***$3,500 Individual***

 ***$7,000 Family Coverage***

**Employee Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Employee Signature Date**