HSA SALARY REDUCTION FORM

EMPLOYEE INFORMATION:

Employee:	Last Name:	First Name:	
ID #:		Date of Birth:	
Street Address:			
City:		State:	Zip
Phone #		Email:	

INSURANCE PLAN:

Insurance Plan:	Kaiser High Deductible HMO
	Circle one: Single Deductible Family Deductible
Insurance Plan:	Sutter Health Plus High Deductible HMO
	Circle one: Single Deductible Family Deductible
Insurance Plan:	Western Health Advantage High Deductible HMO
	Circle one: Single Deductible Family Deductible
Insurance Plan:	Blue Shield of California High Deductible PPO – Out of Area
	Circle one: Single Deductible Family Deductible

CONTRIBUTIONS TO ACCOUNT: **EFFECTIVE DATE:**_____

Monthly Payroll Contribution:	$	Catch up Contribution applies: ***Circle One*** Yes No

2025 Contribution Limits: $4,300/single coverage or $8,550/family coverage
2026 Contribution Limits: $4,400/single coverage or $8,750/family coverage

***A Catch-Up Contribution of up to $1,000 during the 2025 & 2026 calendar year is allowed for subscribers who are over 55 years of age. ***

I do hereby authorize my School District to deduct the stated amount from my pay warrant and deposit it into the custodial account of the bank who holds my HSA.

_____ _____
Employee Signature Date

_____ _____
District Approval Date