

## OPTUM HSA SALARY REDUCTION 2026

### EMPLOYEE INFORMATION:

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

### INSURANCE PLAN:

|                 |   |  |
|-----------------|---|--|
| Insurance Plan: | Kaiser High Deductible HMO                                  |  |
|                 | <i>Circle one:</i> Single Deductible      Family Deductible |  |
| Insurance Plan: | Sutter Health Plus High Deductible HMO                      |  |
|                 | <i>Circle one:</i> Single Deductible      Family Deductible |  |
| Insurance Plan: | Western Health Advantage High Deductible HMO                |  |
|                 | <i>Circle one:</i> Single Deductible      Family Deductible |  |
|                 |   |  |

### CONTRIBUTIONS TO ACCOUNT:      EFFECTIVE DATE: \_\_\_\_\_

|                               |    |  |
|-------------------------------|----|--|
| Monthly Payroll Contribution: | \$ | Catch up Contribution ** Included:<br><i>Circle One</i> Yes    No<br>\$_____ |
| Total Annual Contribution     | \$ |  |

**2026 Contribution Limits: \$4,400/single coverage or \$8,750/family coverage**

*\*\*A Catch-Up Contribution of up to \$1000 during the 2026 calendar year is allowed for account holders who are over 55 years of age.*

I do hereby authorize my employer to deduct the stated amount from my pay warrant and deposit it into the custodial account with Optum Bank.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
District Approval

\_\_\_\_\_  
Date