



HEALTH SAVINGS ACCOUNT (HSA)

EMPLOYEE CONTRIBUTION ELECTION/CHANGE FORM (Complete and return to HR)

Employer Name: College of the Holy Cross

HSA ACCOUNT OWNER'S NAME AND ADDRESS

Last Name First Name Middle Initial

Street Address

City State Zip Code

Employee ID Number

CONTRIBUTIONS

- I wish to change my contribution to my HSA account as soon as administratively possible. Please change my HSA contribution to \$_____ each remaining pay period on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise.
I wish to change my contribution to my HSA account effective _____. Please change my HSA contribution to \$_____ each remaining pay period on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise.

SIGNATURE

It is my responsibility (1) to determine whether I am eligible to make contributions to my HSA, and (2) to determine whether contributions to this HSA have exceeded the applicable maximum annual contribution limit.

HSA Account Owner Date

Table with 3 columns: 2024 Annual Maximum Contribution*, 2024 College Contribution**, 2024 Maximum Employee Contribution. Rows for Single and Family.

* If age 55 or older, an additional catch-up contribution of \$1,000 is allowed annually.
** Note - For new employees hired after 1/1/24, the College Contribution will be pro-rated as of the first of the month coincident with or next following your date of hire.