The Employer Group
The Human Resource Resource™

Health Savings Account (HSA)
2024 Pre-tax Deduction Authorization/Change Form
For Use with High-Deductible Health Plans ONLY

Use this form to establish or request a change to your Health Savings Account (HSA) payroll deduction or to communicate your HSA account information into which your employer's HSA contribution will be deposited. Submit the forms to The Employer Group via fax to 800-319-0516 or email at info@theemployergroup.com. Keep a copy for your records.

Section 1: Employee Information

Full Name:	Last Four Digits of Social Security Number:

Section 2: Action Request

- ☐ **Start** my pre-tax HSA payroll deduction. (Complete Sections 3, 4, 5 and attached direct deposit form)
- ☐ **Stop** my pre-tax HSA payroll deduction. (Complete Sections 4 and 5)
- ☐ **Change** my pre-tax HSA payroll deduction amount. (Complete Sections 3, 4 and 5)
- ☐ **Change** my pre-tax HSA direct deposit account. (Complete 4, 5 and attached direct deposit form)
- ☐ **I am not contributing to an HSA, but my employer offers an HSA contribution.** My employer's contribution should be deposited into my HSA account. (Completed attached direct deposit form.)

Section 3: HSA Payroll Deductions

IRS Contribution Limits for 2024 Calendar Year, including any applicable employer contribution:	**Individual HSA**	**Family HSA**	**Over 55 Catch-Up**
	$4,150	$8,300	$1,000

I elect to contribute $_____ per year to my HSA account. This amount will be prorated on a per-payroll basis. This request replaces any previous payroll deductions for my HSA, if applicable.

Section 4: Effective Date

☐ Next available pay date** **OR** Future Pay Day: _____/_____/_____

**Will occur as early as the next pay period available for processing. For new employees, HSA contributions will begin upon eligibility of healthcare coverage.

Section 5: Acknowledgement & Signature

- I authorize a reduction in my pay before taxes on a per-pay period basis, as indicated above.
- It is my responsibility:
  - to determine whether I am eligible to make contributions to my HSA and to be compliant with IRS rules;
  - to ensure the account established to receive HSA funds is a tax-exempt trust or custodial account you set up with a qualified HSA trustee;
  - to determine whether contributions to this HSA have exceeded the applicable maximum annual contribution limit (which includes employee contributions plus employer contributions, if applicable). I acknowledge that I may be liable for tax penalties if I exceed this amount.
- I understand that my election will remain in effect until a HSA Pre-tax Deduction Authorization/Change Form is submitted to The Employer Group.
- I understand that changes can be made monthly, and that my changes must be prospective in accordance with Internal Revenue Code (IRC) rules.
- All aspects of managing and maintaining the HSA, including any fees associated with the account, are the responsibilities of the employee. I am responsible for ensuring contribution elections are taken correctly from my pay and contributed to my account by monitoring my HSA account activities with my financial institution.

_____ _____

Signature Date

FOR THE EMPLOYER GROUP USE ONLY:

First pay period for new HSA deduction: _____

Health Savings Account (HSA)
Pre-Tax Authorization Agreement
For Automatic Deposits (Credits)

Employee Name: _____	Please	☐ New HSA account
Worksite Employer: _____	check	☐ Change in HSA account
Last 4 Digits of Social Security Number: _____	one:	

For accuracy, please attach a copy of a document from your bank listing your type of account, routing number, and account number:

I hereby authorize The Employer Group to deposit my elected pre-tax HSA contributions and/or any HSA contribution from my employer by initiating credit entries to my HSA-compliant account at the financial institution indicated below. Further, I authorize the financial institution listed below to accept and credit entries indicated by The Employer Group to debit my account(s). In the event that The Employer Group deposits funds erroneously into my account(s), I authorize The Employer Group to debit my account(s) for an amount not to exceed the original amount of the erroneous credit.

Financial Institution Name:
City/State/ZIP:
Account Number:
Routing & Transit Number:
☐ Checking ☐ Savings

This authorization is to remain in full force until The Employer Group has received written notification from me of its termination or change in such time and in such manner as to afford it and my financial institution(s) a reasonable opportunity to act on it.

Signature: _____ **Date**: _____

Please return this form via fax to 800-319-0516 or email at info@theemployergroup.com.