

Employee HS	deductio	n form		Health Equity				
Return completed for	ms to:						. ,	
Company name:								
Attn:								
Fax:								
Email address:								
Annual emplo	yer contrib	ution info	rmation					
Self-only			Family		Other (optional)			
For mid-vear enrolled	es contact vour	HR denartment	t for your pro-rated 6	employer election amo	ınt			
Notes		асраганен	e ror your pro rucou c					
HSA contribut	2023 annual HSA				024 annu	al HSA contributions		
Coverage type Total annual contribution*			Per month	Coverage type	Total annual contribution* Per month			
Self-only	\$3,850		\$320.83	Self-only	\$4,150 \$345.8		\$345.83	
Family	\$7,750		\$645.83	Family		\$8,300 \$691		
*Catch-up contribution (age 55+): additional \$1,000/year				*Catch-up contribution (a	*Catch-up contribution (age 55+): additional \$1,000/year			
Total annual contribution		_	Total annual employer contribution			Total eligible amount		
		(MINUS)			=			
Total eligible amount		/ (DIVIDED)	Enter number of pay periods remaining in the year from form submittal date		=	Per-pay period max withholding		
(HDHP). If you're cov contributions. If you	ered as of Decen cease to be an el and subject to a p	nber 1, you're d igible individua	considered an eligibl al during the next ca	e determined by the ef e individual for the ent lendar year, any fundin information or to revie	ire year ar g over the	nd you're not required prorated amount is co	to pro-rate your onsidered an	
Employee info	rmation an	d authoriz	zation					
Employee name				Last 4 of SSN or employee	ID			

_ from my (weekly/bi-weekly/monthly) payroll and apply the funds to my HealthEquity HSA. Please withhold \$ _ Signature