OPTUM HSA SALARY REDUCTION FORM

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 ***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:	Out-of-Area - UnitedHealthcare High Deductible PPO ***Circle one***: Single Deductible Family Deductible

CONTRIBUTIONS TO ACCOUNT: EFFECTIVE DATE:_____

Monthly Payroll Contribution:	$	Catch up Contribution ** Included: ***Circle One*** Yes No $_____
Total Annual Contribution	$	

2018 Contribution Limits: $3,450/single coverage or $6,900/family coverage

***A Catch-Up Contribution of up to $1000 during the 2018 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