

# Health Savings Account (HSA) Payroll Deduction Form



Employees who wish to have monies withheld from their pay and deposited into a Health Savings Account (HSA) on a pre-tax basis must complete this form and be enrolled in the high-deductible plan with HSA before starting the payroll deduction.

## EMPLOYEE INFORMATION

Full Name					
	<i>Last</i>	<i>First</i>	<i>MI</i>	<i>SSN</i>	<i>DOB</i>
Address:					
	<i>Street Address</i>	<i>City, State, Zip</i>			
Home Phone:		Cell Phone:		E-mail:	

Check one:

☐ New Payroll Deduction
 ☐ Replace Existing Deduction
 ☐ Cancel Payroll Deduction

## ANNUAL MAXIMUM HSA CONTRIBUTION LIMITS PER CALENDAR YEAR

Calendar Year	Tier	IRS Annual Limit	Each year the IRS sets maximum contribution limits for Health Savings Accounts (HSAs). Failure to observe these limits may result in tax penalties.
2023	Individual Coverage	\$3,850	
	Family Coverage	\$7,750	
2024	Individual Coverage	\$4,150	
	Family Coverage	\$8,300	

**\*\*Maximum Catch-Up Contributions:** Employees age 55 or older may contribute an additional annual catch-up contribution of \$1,000.

## PAYROLL DEDUCTION INFORMATION

Coverage Type	*Pre-Tax Monthly Contribution Amount	Effective Pay Period Beginning Date
Check one:	(*based on maximum limits noted above)	(enter as 5 <sup>th</sup> day of month: Mo/Day/Yr)
<input type="checkbox"/> Individual Coverage	\$	
<input type="checkbox"/> Family Coverage		

## EMPLOYEE CERTIFICATION AND SIGNATURE

By signing this form, I authorize Floyd County Public Schools to deduct the elected amount from my pay on a tax-deferred basis each pay date and deposit the amount into a Health Savings Account (HSA).

I understand there are maximum limits for HSA contributions and it is my responsibility to manage my contributions based on eligibility in accordance with IRS regulations. The school division will process contributions as directed by this form and I understand that I may be liable for tax penalties if maximum contribution amounts are exceeded as outlined by IRS code. I also understand that in order to avoid tax consequences, it is my responsibility to ensure that claims drawn from this account are eligible medical expenses with substantiated receipts.

This deduction will be considered continuous unless otherwise notified. I understand that I may terminate this authorization by completing this form and submitting a new form to the Payroll/Benefits Office 15 days prior to the next payroll cycle.

\_\_\_\_\_  
Employee (Account Owner) Signature

\_\_\_\_\_  
Date

**FLOYD COUNTY PUBLIC SCHOOLS**

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