Health Savings Account (HSA) Salary Reduction Agreement

HR Use ONLY

☐ HSR

☐ HSA

EMPLOYEE ELECTIONS

Employee Name: _____ **PLU ID #** _____

Department: _____ ☐ **Salaried** ☐ **Hourly**

On separate benefit enrollment form(s), I have enrolled for certain coverages and understand that an amount equal to the total amount of premiums for coverage(s) elected will be withheld from my salary. I elect to receive the following *(check coverage(s) desired)* on a PRE-TAX BASIS under the Health Savings Account (HSA) Salary Reduction Agreement:

Effective: _____ please begin deducting my elective contributions:

(Month / Year)

HSA Contributions	IRS Maximums (2027)	PLU's Contribution		Employee Elective Contribution	
	Includes both EE & ER contributions	Monthly	Annual	Monthly	Annual
Employee Only	**$4,500.00**	$65.00	$780.00		
Family Coverage	**$9,000.00**	$130.00	$1,560.00		
Catch-up Amount for individuals above age 55	**$1,000.00**				

Any previous election and Salary Reduction Agreement under the Premium Conversion Plan relating to the same benefits as selected above is hereby revoked.

IMPORTANT INFORMATION YOU NEED TO KNOW

I understand that:

This Salary Reduction Agreement can only be changed once per month. A new signed Salary Reduction Agreement must be submitted to the payroll department prior to any change. Depending on timing with the payroll production cycle, it is possible that a change will not be able to be implemented until the following month

Execution of this Salary Reduction Agreement does not initiate coverage under the Benefit Plans. Coverage will be determined under the separate Benefit Plan.

Pre-tax contributions paid pursuant to this Salary Reduction Agreement reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes

It is my responsibility to ensure that any contributions to my Health Savings Account comply with IRS regulations.

Amounts remaining in my Health Savings Account after the end of the Plan Year will be rolled over to the following year.

Prior to the Anniversary Date each year I will be offered the opportunity to change my elections for the following plan year. Notwithstanding the foregoing, I understand that this Salary Reduction Agreement for my Health Savings Account (HSA) will remain effective until a new Agreement is completed.

I agree that my compensation will be reduced by the amount of my required contribution for the Benefit Plans I have elected, continuing for each pay period until this agreement is amended or terminated. The amount of my required contribution for each Benefit Plan has been provided to me. I have read and agree to the terms of participation set forth on this form and in the Summary Plan Description provided to me.

_____ _____

Employee Signature Date