



2025 Health Savings Account Change Form

Change Deadline: Last day of the month
All changes will take effect the following month

Last Name: _____

Dept/Loc: _____

First Name: _____

Phone No: _____

SSN Number: _____

Signature: _____

Date: _____

Employee Contribution Limits

Employee: \$4,300

Family: \$8,550

Additional \$1,000 catch up contribution
allowed if employee is 55 years or older.

District Contribution Limits

| | Dollar for Dollar District Match: | Direct Contribution: divided by 24 pays |
|--------------|---|--|
| Employee: | \$400 | \$400 = \$16.67 |
| Employee +1: | \$600 | \$600 = \$25.00 |
| Family: | \$800 | \$800 = \$33.34 |

Please indicate the ***MONTHLY** amount you would like to contribute
beginning with the current month.

Leave previous months blank. We cannot make retro-active changes.

***Amount entered will be split evenly between the two pay periods.**

| Month | Monthly Total | <u>District Use Only</u> Divide by 2 |
|----------|---------------|---|
| January | \$ | |
| February | \$ | |
| March | \$ | |
| April | \$ | |
| May | \$ | |
| June | \$ | |

| Month | Monthly Total | <u>District Use Only</u> Divide by 2 |
|-----------|---------------|---|
| July | \$ | |
| August | \$ | |
| September | \$ | |
| October | \$ | |
| November | \$ | |
| December | \$ | |