2024 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: $4,150 **Family: $8,300**
Additional $1,000 catch up contribution allowed if employee is 55 years or older.

District Contribution Limits		
	$ for $ 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	District UseOnly Divide by 2
January	**$**	
February	**$**	
March	**$**	
April	**$**	
May	**$**	
June	**$**	

Month	Monthly Total	District Use Only Divide by 2
July	**$**	
August	**$**	
September	**$**	
October	**$**	
November	**$**	
December	**$**	