



2026 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: _____
 Employee ID: _____ Last 4 of SSN: _____
 Signature: _____ Date: _____

Employee Contribution Limits
<p>Employee: \$4,400 Family: \$8,750</p> <div> <p>Additional \$1,000 catch up contribution allowed if employee is 55 years or older.</p> </div>

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	\$	