



## HEALTH SAVINGS ACCOUNT PAYROLL DEDUCTION FORM

Use this form to authorize deductions from your paycheck on a pre-tax basis to be automatically contributed to your Health Savings Account. After completing please make a copy for your records and forward the original form back to the Town Clerk's office. If you have any questions when completing this form, please contact the Town Clerk.

**Establish Payroll Deduction for First Time**

**Change Payroll Deduction Amount**

**Stop Payroll Deduction**

\_\_\_\_\_  
Name (Last, First, MI)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

**Amount of Payroll Deduction:** \$ \_\_\_\_\_

**Per Bi-Weekly Pay Period**

**One Time Deduction**

**I do not wish to contribute to my Health Savings Account at this time.**

**2011 Annual Combined Maximums are: Employee Only \$3,050, Employee plus dependent coverage \$6,150; Employees over 55 may contribute an additional \$1,000**

As an eligible employee, I acknowledge that I understand the benefits, rights, and obligations available to me under the plan and that the above deductions, if any, will be made on a pre-tax basis. I am enrolled in the Town of Emerald Isle's Blue Options HSA High Deductible Health Plan and certify that I am not eligible to receive any benefits under another health plan or general purpose FSA. I also understand that in order to avoid tax consequences, it is my responsibility to ensure that funds drawn from my Health Savings Account are eligible expenses with substantiated receipts.

Remember, annual maximums as determined by the IRS are total amounts; you will need to factor in any Town contributions as well when determining your allowable maximum contribution for tax purposes. The management of the HSA and additional related funding is the responsibility of the employee. The funds deposited to your HSA will belong solely to you, not the Town. Therefore, these funds roll over from year to year and continue to be available even after employment ends. These monies remain tax-free if used for qualified medical expenses (including dental, vision, etc.)

**Employee's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_