



## 2018 Healthcare Savings Account Contribution Form

### *Personal Information (Please Print or Type)*

Associate Name: \_\_\_\_\_

Associate Number: \_\_\_\_\_

Location Code: \_\_\_\_\_

### **Part I – Change Contribution**

I request that my future earnings from the company be reduced by the amount indicated below. The amounts deducted from my earnings will be contributed into my Healthcare Savings Account. I understand that I may contribute up to the annual contribution limit of \$3,450 for an individual or \$6,900 for two or more in the plan. This deduction will continue in effect for future earnings until changed by me in writing in accordance with plan provisions for calendar year 2018.

For Associates who are 55 or older, you can put an additional \$1,000 into your Health Savings Account during the calendar year. This would make the total contribution allowed \$4,450 for an individual, \$7,900 for two or more in the plan.

Please deduct per bi-weekly (or weekly) paycheck \$\_\_\_\_\_ from my earnings to be deposited into my Healthcare Savings Account. (Minimum \$25.00 per paycheck; (\$12.50 for weekly properties)).

**This change will be in effect following the first paycheck it is received.**

Associate Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Part II – Discontinue Contributions**

I request to discontinue my contribution to my Healthcare Savings Account. I understand I may resume contributions on the beginning of any month.

Discontinue my deduction for my Healthcare Savings Account.

This change will be effective the first paycheck after this form is received in the State College Office.

Associate Signature \_\_\_\_\_ Date \_\_\_\_\_

**This form is for associates enrollment in the Capital Blue Cross**