

# El Paso Independent School District Health Savings Account (HSA) Authorization for Payroll Deduction/Change Form

Name: Last \_\_\_\_\_ First \_\_\_\_\_

S.S# : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Is this a new HSA enrollment or a change to your current contribution? (Please check one):

**NEW** \_\_\_\_\_

**CHANGE** \_\_\_\_\_

Type of Coverage:

**Individual** \_\_\_\_\_

Annual Maximum (\$3,050)  
\*Additional \$1,000 if over age 55

**Family** \_\_\_\_\_

Annual Maximum (\$6,150)  
\*Additional \$1,000 if over age 55

I am a participant of the Consumer Driven Health Plan 3000 (CDHP) and hereby authorize El Paso Independent School District to deduct the following amount from my paycheck \$ \_\_\_\_\_

I am requesting this deduction to be taken for # \_\_\_\_\_ pay periods for a total of \$ \_\_\_\_\_

My Annual HSA Contribution is \$ \_\_\_\_\_

I understand that this deduction will be deducted from my pay on a semi-monthly basis.

Please submit the completed Form to Employee Benefits. Deductions will be entered on the following payroll cycle.

I certify that I am eligible to establish an HSA and that the information I have provided is true and correct. I agree to comply with all laws and regulations governing HSA's and acknowledge that Aetna, it's affiliates and contractors shall not be liable for any tax or other consequences related to my establishment, funding or use of the HSA.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Entered by:

\_\_\_\_\_  
Date