Health Savings Account Enrollment Form

Employee Name	Social Security Number	
Address	City/State/Zip	
Email Address	Date of Birth	Date of Hire
Effective Date of Election	First Pay Date	
Health Saving Account	Per Pay Contribution	Plan Year Contribution
Maximum ☐ Single $3,500 ☐ Family $7,000		

My employer and I hereby agree that my cash compensation will be redirected by the amounts set forth above for each pay period during the Plan Year (or during such portion of the year that remains after the date of this agreement). I understand that if I do not return this form to my employer by my effective date, I understand that:

- I can discontinue, increase or decrease the amount of my Health Savings Account contributions at any time during the Plan Year.
- The Plan Administrator may reduce or cancel my taxable compensation redirection or otherwise modify this agreement in the event it is believed that it is advisable in order to satisfy certain provisions of the Internal Revenue Code.
- This agreement is subject to the terms of the Company's Flexible Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior election and Taxable Compensation Redirection Agreement relating to such plan(s). By signing this form, I agree to the terms and procedures listed herein.

Employee Signature _____ Date _____

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