ST. MICHAEL ALBERTVILLE SCHOOLS

EXCELLENCE IS OUR TRADITION

HEALTH SAVINGS ACCOUNT (HSA)
EMPLOYEE CONTRIBUTION ELECTION FORM

(This form must be received by payroll at least 4 business days in advance of date elected below)

_____ _____ _____

Last Name First Name Middle Initial

Please check one of the following:

☐ I wish to contribute $_____._____ to my HSA account each pay period on a pre-tax basis.

I understand this amount will be deducted from my paycheck until I indicate otherwise starting:

_____ _____ _____

Month Day Year

☐ I wish to make a single contribution of $_____._____ to my HSA account on a pre-tax basis.

I understand this amount will be deducted from my paycheck one time only on:

_____ _____ _____

Month Day Year

It is my responsibility (1) to determine whether I am eligible to make contributions to my HSA and (2) to determine whether contributions to this HSA have exceeded the applicable maximum annual contribution limit.

_____ _____

Signature Date

Return completed form to
St Michael-Albertville Public Schools District Office
11343 50th St NE
Albertville MN 55301