

Santa Clara County  Office of Education

Health Savings Account Contribution Form 2024

Account Owner's Name & Address		Submit Forms To
Last Name	First Name MI	Human Resources Employee Benefits MC 264
Street Address		
City	State Zip	
Employee ID Number	Daytime Phone	Account Coverage <input type="checkbox"/> Single <input type="checkbox"/> Employee + Dependents

Employee HSA Contributions	
I authorize to deduct from my paycheck the following amount for contributions to my Health Savings Account to begin on _____. This authorization will continue in effect until a timely termination is submitted by me.	
<input type="checkbox"/> Please deduct the following amount per payroll period Single Maximum: \$4,150.00* Family Maximum: \$8,300.00 *	\$ _____
<input type="checkbox"/> Please deduct the following amount in _____ lump sums. Single Maximum: \$4,150.00 * Family Maximum: \$8,300.00 *	\$ _____
<input type="checkbox"/> Please STOP contributions	

*If you are 55 or older you are allowed an additional \$1,000.00 as a catch-up contribution to your HSA.

Employee Signature

Date