**2014 Payroll Deduction Authorization for Health Savings Account**

You may have your employer deduct your HSA contribution from your pay.

Before deciding on the amount to be withheld each pay period:

 Review the annual contribution limits that fit your insurance coverage (Single or Family).

The **2014** tax year limits are as follows: **Single coverage** - $3,300 including any employer contribution. **Family Coverage** (2 or more people on your policy) - $6,550 including any employer contribution. **If you are age 55 or older** at any time during the tax year, add $1,000 to the numbers above.

**Subtract** any employer contributions from your annual limits above. (Example: Your annual limit is $3,300; your employer contribution is $500; you may contribute up to $2,850 through payroll deductions.)

 If you are not covered by a high deductible health plan (HDHP) for the full calendar year (January 1 through December 31), prorate your annual limit based on the number of full months you will be covered by the HDHP.

 **Review HSA Eligibility Requirements:**

If you do not meet all of the following eligibility requirements, federal regulations prohibit you from opening an HSA:

* Covered under a qualified high deductible health plan on the first day of the month.
* Not covered by any other health plan, including your spouse’s health insurance.
* Not covered by spouse’s Medical Flexible Spending Account (FSA).
* Not enrolled in any part of Medicare or Tricare.
* Have not received Veteran’s health benefits in the past 90 days.
* Not claimed as a dependent on another person’s tax return.

I authorize my employer to deduct (amount) $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per pay period from      
from my paycheck.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Return completed form to HR Manager/Employer. Please do not send to Health Savings Administrators.***