EMPLOYEE AUTHORIZATION FOR PAYROLL DEDUCTION TO HEALTH SAVINGS ACCOUNT

Use this form to have your employer withhold money from your paychecks and deposit it into your Health Savings Account (HSA) on a pre-tax basis.

I wish to:			
☐ Begin a deduction	☐ Change my deduction	☐ Stop my deduction	Effective Date: (1st of next month)

Section 1: Employee Information	
Name (Last, First, MI)	
Street Address	**Work phone number**
City/State/Zip	**Employer Name**

Section 2: HSA Eligibility and Contribution Limits

Review the following information about limits on HSA contributions and complete Section 3 to authorize HSA contributions to be deducted from your pay.

To be eligible to make or receive HSA contributions, you must be enrolled in a High Deductible Health Plan (HDHP) and you cannot be covered under any "Disqualifying Coverage". Disqualifying Coverage includes Medicare, a Regular (General-Purpose) Health Care FSA, or any group health plan (including a spouse's plan) that is not an HDHP, but does not include plans that provide only limited benefits, such as a dental plan or a Special-Purpose Health Care FSA. Eligibility is determined on a month-to-month basis.

Under federal tax law, total contributions to your HSA for all of calendar year 2024 (including contributions made by your employer) are limited to $4,150 ($5,150 if you will be age 55 or over on 12/31/2024) if you are enrolled in HDHP coverage that covers only you, or $8,300 ($9,300 if you will be age 55 or over on 12/31/2024) if you are enrolled in HDHP coverage that covers you and any other person.

If you are married and either you or your spouse has HDHP coverage that covers more than one person, your contribution limit could be reduced based on amounts contributed to your spouse's HSA, so you should consult your tax advisor.

Also, note that if you are eligible for HSA contributions for only part of the calendar year, the federal HSA contribution limit that applies to you is prorated based on the number of months in 2024 that you are eligible for HSA contributions. For example, if you are eligible for only six months during 2024, your maximum contribution would be one-half of the limit that would apply if you were eligible for all 12 months of 2024.

The IRS limit on HSA contributions is subject to increase based on inflation each calendar year. If you wish to increase your contributions for 2024 because of any change that applies for 2024, you may submit a new copy of this form at any time after the new limits are announced.

For eligible employees enrolled in an HDHP offered through the Archdiocese's plan, your employer currently contributes $500 per year for anyone covered under individual HDHP coverage for the full Plan Year or $1,000 for anyone covered under family HDHP coverage for the full Plan Year. The employer contribution will be made on a quarterly basis and will be pro-rated based on when you enroll during the plan year. For example, a new hire starting in September will be eligible 10/1 and the employer contribution for individual coverage will be based on the remaining nine months left in the plan year (or $125.00 paid over the next three quarters for a total of $375.00). The amount of the Employer contribution is subject to change at the discretion of the Employer.

WE RECOMMEND THAT YOU DISCUSS THESE ISSUES WITH YOUR TAX OR FINANCIAL ADVISOR.

Section 3: Employee Payroll Deduction Authorization

I elect to make the following contribution to my HSA, through pre-tax payroll deduction. I understand that total contributions to my HSA (including contributions made by the Employer, if any) are subject to certain legal limits (as summarized above). I understand that I am responsible for determining if my contributions are within any limit that applies to me. By selecting this option and signing this Form, I certify that I will be covered under a High Deductible Health Plan and will not be covered under any Disqualifying Coverage for the current year (or, if applicable, any later Effective Date entered above) and I agree that I will promptly inform the Employer if I cease to be covered under an HDHP or if I become covered under any Disqualifying Coverage at any time during the current Plan Year.

I understand that my elections will continue unless I cease to be covered under an HDHP; make a new election to stop, decrease or increase my contributions; or cease to be an eligible employee before that date. I understand that I may change my election to contribute to my HSA for any reason, at any time, up to one time per month. This Form replaces any previous payroll deduction authorization for contributions to my HSA.

By signing below, I acknowledge that I have read Section 2, HSA Eligibility and Contribution Limits, and agree to contribute*: $_____ for the Plan Year (or the remainder of the current Plan Year), divided by _____Pay Periods** = $_____ Per Pay Period.

** **The employer contribution ($500 for individual or $1,000 for 2+ coverage or the pro-rated amount for the remainder of the calendar year) is included in the plan year limit. If you want to contribute up to the limit, ensure you deduct the employer amount.***

*** Please contact your direct employer or the Employee Benefits Office at insure@archbalt.org for help in determining the number of pay periods and the amount of your per paycheck deduction.*

_____ _____

Employee's Signature **Date**

Please return this form to your direct employer.

Local HR/Benefits office use

Employee's annual contribution	Number of paychecks remaining for plan year or calendar year	Employee's contribution per paycheck
$_____	_____	$_____