HSA Election

Health Savings Account Election Form

DRIVEN 125 BENEFIT ADMINISTRATORS

EMPLOYEE INFORMATION

Full Name	
Date of Birth	
Address	
Phone Number	
Email Address	

HSA ELECTION

☐ **I elect to contribute to my HSA an amount of $ per payroll. I agree that my regular compensation will be reduced by the amount of my HSA election during the calendar year. I understand that I may change my HSA election anytime during the calendar year, subject to the dollar limits described above.1**

ELIGIBILITY

☐ **I confirm that I am not enrolled in other health insurance, including Medicare.**

AUTHORIZATION

I authorize my employer to deduct the HSA elections I have indicated on this form from my paycheck. This authorization replaces any previous authorization. I acknowledge that my employer is not responsible for any individual tax consequences that may result from my elections

Date:

Employee Signature