MOSINEE SCHOOL DISTRICT

2018 HEALTH SAVINGS ACCOUNT (HSA) EMPLOYEE CONTRIBUTION FORM

Employee Name: _____

Amount to be deducted per pay period in 2018: _____

2018 HSA Limits are $3,450.00 Single and $6,900.00 Family. For those 55 or older, you can contribute an extra $1,000.00 under the catch-up provisions. You will need to reduce these amounts by the District contribution of $300.00 on a single plan and $600.00 on a family plan (part time employees on health plan receive a prorated benefit). **If you only wish to receive the District contribution and not make a voluntary contribution yourself, please write in "District Contribution Only" on the line above.**

Deduction to begin on: _____

January 12, 2018 is first pay date of the calendar year. **Please indicate desired payroll start date above**.

HSA Financial Institution: CoVantage Credit Union

HSA Account Number: _____

HSA Routing Number: 275976655

I authorize Mosinee School District to deduct, on a pre-tax basis, the above amount from my paycheck beginning on the date noted above. I have confirmed the bank account and bank account number.

Terms of having a Health Savings Account with the District:

- I will be able to change this contribution amount as needed with a 14 day notice to the District Office along with completion of this form with the new amounts indicated on it. We will notify you as to the exact date your new deduction amount will start once we receive your revised request.
- Once funds have been deposited into my HSA, it is my responsibility to become familiar with and to comply with the laws and regulations pertaining to my HSA account.
- It is my responsibility to ensure that I do not exceed the IRS allowed annual maximum that can be contributed to an HSA account.
- That I am covered under a qualified High Deductible Health Plan (the District Health Plan is qualified).
- That I am not covered under any other health plan that is not a High Deductible Health Plan.
- I am not enrolled in Medicare.
- I am not signed up for a full medical flex plan through another employer or my spouse's employer.
- I am not claimed as a dependent on another person's tax return.

My signature below indicates my agreement with the statements found above and my compliance with the rules of having a Health Savings Account.

_____ _____

Employee Signature Date