BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

HEALTH SAVINGS ACCOUNT EMPLOYEE CONTRIBUTION ELECTION FORM

(To be completed and returned to your employer)

Employer Name: _____

ACCOUNT OWNER'S NAME AND ADDRESS

_____

Last Name **First Name** **Middle Initial**

_____

Street Address

_____**City**

State **Zip Code**

_____

Social Security No. **Date of Birth** **Daytime Phone** **Evening Phone**

CONTRIBUTIONS

☐ I wish to contribute $_____to my HSA account each pay period on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise.

☐ I wish to make a single contribution of $_____to my HSA account on a pre-tax basis. I understand this will be deducted from my paycheck one time only for the tax year _____.

SIGNATURE

It is my responsibility 1) to determine whether I am eligible to make contributions to my HSA; And 2) to determine whether contributions to this HSA have exceeded the applicable maximum annual contribution limit.

_____ _____

Account Owner Date