

Health Savings Account (HSA) Contribution Change Form

HDHP PPO & Health Savings Account (HSA) Plan

Complete this form to make a mid-year change to your Health Savings Account annual contribution amount. Return to University Human Resource Services, ATTN: Records, Poplars E165, 400 E 7th Street, Bloomington, IN, 47405, or scan and email to recben@indiana.edu, or fax to 812-855-3409.

EMPLOYEE INFORMATION:

Employee Name (Last, First, MI): _____ 10-digit ID: _____

Campus: _____ Campus Phone: (____) ____ - _____ Department: _____

Medical coverage (check one): Employee Family*

*Family coverage includes Employee w/Spouse, Employee w/Child(ren), and Family HDHP coverage levels

CHANGE TO CURRENT HEALTH SAVINGS ACCOUNT ANNUAL CONTRIBUTION AMOUNT:

The contribution deducted from each remaining 2012 pay period will be automatically computed by the payroll system. The computation will take into account your new ANNUAL contribution request, subtract what you've already contributed, then divide by the number of remaining pay periods. The number of remaining pay periods is determined by when this form is received and processing is completed. (Pay calculations close approximately one week before pay is issued; forms received after a pay period closing are not processed until the following pay period.)

Enter your new total 2012 ANNUAL contribution: \$ _____

(You may not reduce your annual amount below what you have contributed to date as refunds are not an option. The annual contribution must be an amount between the minimum and maximum as described below.)

Minimum annual contribution is the greater of:

- The plan minimum of \$300 annual contribution; OR
- Your accumulated year-to-date contribution as of your last pay check.

Maximum annual contribution (Limits shown below are less the university's \$1,200 Employee-only or \$2,400 Family contribution.)

Under age 55:

- Employee-only HDHP.....\$1,900
- Family HDHP*.....\$3,850

Age 55 or older (includes \$1,000 catch-up):

- Employee-only HDHP.....\$2,900
- Family HDHP*.....\$4,850

*Family coverage includes Employee w/Spouse, Employee w/Child(ren), and Family HDHP coverage levels

Employee Authorization:

I authorize IU to withhold my contributions for this plan from my pay on a pre-tax basis. The per-pay period contribution will be determined by subtracting my year-to-date payroll deductions from the new elected annual amount and dividing over the remaining pay periods for the year.

SIGNATURE: _____ DATE: ____/____/____

**FOR UHRS
USE ONLY:**

Date Received

Entered By

Date Entered