

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM For State Centralized Payroll Employees

1. MEMB	BER INFORMATION								
Member Name			First				Middle Initial		
Social	Security Number		Payroll Num	ber		Date	1	1	
	•								
2. PAYRO	OLL REQUEST								
ар	authorize my employer to bre-tax basis beginning no gible to be deposited into m	earlie	er than the date my HS						
allo trib	Contributions are subject to federal limits. Annual limits for 2020: \$3,550 for individuals; \$7,100 for families. Additiona allowable contributions for individuals between the ages of 55-65: \$1,000 for the account holder only. Cortributions will begin after your HSA bank account has been opened with the banking institution selected by you provider.								
No	Note: Employer contributions to your HSA count toward the annual limit.								
Ple	Please fill in the desired amount below.								
De	duct \$	per pay period.							
	ncel deductions for the Hea			avch	eck.				
			, , , , , , , , , , , , , , , , , , ,	.,					
3. HEAL	TH PLAN								
High D	Peductible Health Plan (HI	OHP) (Check one)						
	NJ DIRECT HD1500		NJ DIRECT HD4000						
Covera	age Level (Check one)								
_	0: 1					<i>(</i> 0: ::.::	5 .		
	Single				Member and Spouse			ier	
	Family			Ц	Member and Domest	ic Partner			
	Parent and Child(ren)								
Member S	Signature					_ Date	/	/	
Please re	turn the completed form	to:	N.J. Department of the T	reası	ıry				

OMB – Centralized Payroll

P.O. Box 207

33 West State Street, 2nd Floor Trenton, NJ 08625-0207