



State Health Benefits Program (SHBP)

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM**MEMBER INFORMATION**
 Member Name _____
Last *First* *Middle Initial*

Social Security Number _____ Location Number _____ Date ____/____/____

PAYROLL REQUEST — Choose one

- I authorize my employer to deduct the Health Savings Account (HSA) contribution identified below on a pre-tax basis beginning no earlier than the date my HSA medical plan will become effective. The funds are eligible to be deposited into my Health Savings Account.

Contributions are subject to federal limits. Annual limits for 2022: \$3,650 for individuals; \$7,300 for families. Additional allowable contributions for individuals between the ages of 55-65: \$1,000 for the account holder only. Contributions will begin after your HSA bank account has been opened with the banking institution selected by your provider.

Note: Employer contributions to your HSA count toward the annual limit.

Please fill in the desired amount below.

Deduct \$ _____ per pay.

- Cancel deductions for the Health Savings Account from my paycheck.

HEALTH PLAN**High Deductible Health Plan (HDHP) (Check one)**
 NJ DIRECT HD4000

 NJ DIRECT HD1500
Coverage Level (Check one)
 Single

 Member and Spouse/Civil Union Partner

 Family

 Member and Domestic Partner

 Parent and Child(ren)

Member Signature

 ____/____/____
Date

**Please do not send the completed form to the Division of Pensions & Benefits.
Submit this form to your employer.**

BENEFITS ADMINISTRATORS: RETAIN THIS FORM FOR YOUR FILES