INDIANA UNIVERSITY

Health Savings Account (HSA) Enrollment/Change Form (2019 Plan Year)

HUMAN RESOURCES

IMPORTANT INFORMATION—PLEASE READ BEFORE COMPLETING THIS FORM

The contribution deducted from each 2019 pay period will be automatically computed by the payroll system. The computation will take into account your ANNUAL contribution request, subtract what you've already contributed (if applicable), then divide by the number of remaining pay periods (assuming twelve months of 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.) 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.

The **Minimum Annual Contribution** is the greater of: The plan minimum of $300; OR your accumulated year-to-date contribution as of your last pay check. **Maximum Annual Contributions** listed below are less the university's contribution. Contribution maximums are dependent on the plan you are enrolled in and the level of coverage. Employees aged 55 or older may also make a $1,000 additional "catch-up" contribution.

AGE & LEVEL OF COVERAGE	IU HEALTH HDHP	ANTHEM PPO HDHP
Under age 55:		
Employee-only Coverage	$1,900	$2,200
All Other Coverage Levels	$3,800	$4,400
Age 55 or older (includes $1,000 catch-up):		
Employee-only Coverage	$2,900	$3,200
All Other Coverage Levels	$4,800	$5,400

ACTION REQUEST

☐ **START** HSA CONTRIBUTIONS
Open an HSA in my name and set my 2019 ANNUAL contribution pledge at $_____. I understand this amount will be divided equally over the remaining number of paychecks in the year. I certify that I meet the eligibility requirements for an HSA and have reviewed and agree with the Custodial Agreement, Designation of Representative, and the Nyhart banking fees.

☐ **CHANGE** HSA CONTRIBUTIONS
Enter your updated 2019 ANNUAL contribution pledge $_____. I understand this amount (minus any prior YTD contributions) will be divided equally over the remaining number of paychecks in the year.

☐ **STOP** HSA CONTRIBUTIONS
☐ Suspend my contributions. I certify that I have contributed at least the minimum annual contribution of $300 or more.
☐ Stop my contributions. I am no longer an eligible individual to make contributions to a Health Savings Account. I understand this will transition my account to an individual account that is no longer associated with IU. I further understand that I will now be responsible for the monthly account maintenance fees associated with the account.

EMPLOYEE INFORMATION

Employee Name:		**University 10-Digit ID:**
Campus:	**Department:**	**Phone:**
Email:		
Medical Coverage Level: ☐ Employee Only ☐ Family*		**Pay Cycle:** ☐ Biweekly ☐ Monthly

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:**

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

Return completed form to: askhr@iu.edu, or

Mail to: IU Human Resources
Poplars E165, 400 E. 7th Street
Bloomington, IN 47405-3085

HR USE ONLY
Date Received: _____
Entered By: _____
Date Entered: _____

RESET PRINT SUBMIT