



HSA – Employee Payroll Contribution Change Form

EMPLOYER: **Los Rios Community College District**

1 <i>Instructions:</i>					
1) Use this form to make a change to your HSA payroll contribution. 2) Submit completed form to your Employee Benefits Department. <i>(Please note that changes to your HSA payroll contributions will become effective the 1st of the month following the submission of your completed form.)</i>					
2 <i>Employee Information</i> - Please print clearly					
FIRST NAME:		LAST NAME:		7 digit EE ID #:	
MAILING ADDRESS			CITY	STATE ZIP CODE	
DATE OF BIRTH	DAYTIME PHONE NUMBER	E-MAIL ADDRESS (required)			
3 <i>Make Your Payroll Contribution Change</i> - Enter your contribution amount.					
<p>Contributions over the cash minimum qualify to be invested and will be placed by default into an interest-bearing account. If you would like to change your investment allocation, you may do so by logging in to your account at http://www.basicpacific.com/. Future contributions will be allocated according to your investment allocation instructions. If you have any questions regarding making a contribution to your HSA, please call BASIC pacific Customer Service at 916-303-7090 or 800-574-5448.</p> <p>Contribution Amount: \$ _____ per pay period</p> <p>Contribution Type: Normal Contribution (includes a regular or catch-up HSA payroll contribution)</p> <p>Your HSA payroll contribution will become effective on the 1st of the month following submission of your completed form to your Employee Benefits Department.</p> <p><i>If you would like to schedule your contribution change for later date, please specify below:</i></p> <p><i>Optional: Effective Date for future Payroll Contribution Change:</i> _____</p>					
4 <i>HSA Accountholder Signature</i>					
<p>I certify that I am the HSA accountholder or an individual authorized to execute this transaction. I have read and understand the instructions and any rules or conditions relating to and have met the requirements for making this transaction. I assume full responsibility for this transaction and will not hold TPA or Healthcare Bank liable for any adverse consequences that may result. I have not received tax or legal advice from TPA or Healthcare Bank and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws. All information provided by me is true and correct and may be relied upon by TPA and Healthcare Bank. I hereby authorize my employer to deduct the amounts listed above from my compensation.</p>					
<p>HSA Accountholder SIGNATURE: _____ DATE: ____ / ____ / ____</p>					
5 <i>To be completed by Employer</i>					
AUTHORIZED EMPLOYER SIGNATURE _____		CIRCLE PAYCYCLE: 10 / 12 CIRCLE PAYDATE: 10th / EOM Employee Unit: _____	PAYROLL CHANGE EFFECTIVE DATE: _____ Coverage Type: S / F ER Contribution : _____		