HSA – Employee Payroll Contribution Change Form

EMPLOYER: **Los Rios Community College District**

1	***Instructions:***
	1) Use this form to make a change to your HSA payroll contribution. 2) Submit completed form to your Employee Benefits Department. (*Please note that changes to your HSA payroll contributions will become effective the **1st of the month** following the submission of your completed form*.)
2	***Employee Information -*** 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	***Make Your Payroll Contribution Change*** - Enter your annual contribution amount.
	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**. **Employee Contribution Amount: $_____ per year** Please note that the annual maximums are based upon the sum of all employee and employer contributions for the calendar year. Be sure to factor both types of contributions when determine your annual contribution. **Your HSA payroll contribution will become effective on the 1st of the month following submission of your completed form to your Employee Benefits Department.** *If you would like to schedule your contribution change for later date, please specify below:* *Optional: Effective Date for future Payroll Contribution Change*: _____
4	***HSA Accountholder Signature***
	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.
	HSA Accountholder SIGNATURE:_____ **DATE**: ____/____/____
5	***To be completed by Employer***

AUTHORIZED EMPLOYER SIGNATURE	CIRCLE PAYCYCLE: 10 / 12 CIRCLE PAYDATE: 10th / EOM Employee Unit: _____	PAYROLL CHANGE EFFECTIVE DATE: _____ Coverage Type: S / F ER Contribution : _____
_____		