HA-0913-1024

State Health Benefits Program (SHBP)

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM

For State and Local Government Employees

MEMBER INFORMATION

Member Name_____
Last *First* *Middle Initial*

Social Security Number_____ Location/Payroll 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 2025: $4,300 for individuals; $8,550 for families. Additional allowable contributions for individuals age 55 or older: $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 period (State biweekly employees) ☐ month (State monthly and local government employees)

☐ I am age 55 or older and wish to contribute an additional $1,000 per year.

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

HEALTH PLAN

High Deductible Health Plan (HDHP) (Check one)

☐ Horizon NJ DIRECT HDLow ☐ Horizon NJ DIRECT HDHigh

☐ Aetna Freedom HDLow ☐ Aetna Freedom HDHigh

Coverage Level (Check one)

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Family ☐ Member and Domestic Partner

☐ Parent and Child(ren)

_____ _____/_____/_____
Member Signature *Date*

Note: State employees who enroll in the Aetna or Horizon HDLow plan will receive $300 in employer funding. Local employers can elect to fund their own amounts or choose not to fund the HSA.

Please return this completed form to your Human Resources department.