COLLEGE OF THE Holy Cross

**HEALTH SAVINGS ACCOUNT (HSA)**
**EMPLOYEE CONTRIBUTION ELECTION/CHANGE FORM** (Complete and return to HR)

**Employer Name:** _____College of the Holy Cross_____

**HSA ACCOUNT OWNER'S NAME AND ADDRESS**

| **Last Name** | **First Name** | **Middle Initial** |
|---|---|---|

____N/A_____
Street Address

| _____N/A_____ | N/A | N/A |
|---|---|---|
| City | State | Zip Code |

_____
**Employee ID No.**

**CONTRIBUTIONS**

☐ I wish to change my contribution to my HSA account as soon as **administratively possible**. Please change my HSA contribution to $_____ each remaining pay period on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise.

☐ I wish to change my contribution to my HSA account effective _____. Please change my HSA contribution to $_____ each remaining pay period on a pre-tax basis. I understand this amount will be deducted from my paycheck until I indicate otherwise.

**SIGNATURE**
It is my responsibility (1) to determine whether I am eligible to make contributions to my HSA, and (2) to determine whether contributions to this HSA have exceeded the applicable maximum annual contribution limit.

_____ _____
HSA Account Owner Date

| | **2023 Annual Maximum Contribution** | **2023 College College Contribution*** | **2023 Maximum Employee Contribution** |
|---|---|---|---|
| *Single:* | *$3,850* | *$500* | *$3,350* |
| *Family:* | *$7,750* | *$1,000* | *$6,750* |

*** If age 55 or older, an additional catch-up contribution of $1,000 is allowed annually.*

*Note – For new employees hired after 1/1/23, the College Contribution will be pro-rated as of the first of the month coincident with or next following your date of hire.