MILFORD
EXEMPTED VILLAGE SCHOOLS

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# 2021 H.S.A Employee Contribution Form

***Plan Year: January 1, 2021 – December 31, 2021*** ***Semi- monthly payments***

**Participant Information:**

SSN # _____
Last Name _____ First_____ Middle _____
Birth Date _____
Male_____ Female_____
Marital Status: Married_____ Single_____
Street Address _____
City _____ State _____ Zip Code _____
Phone Number _____ Email _____
Plan Type: Single_____ Family_____

**HEALTH SAVINGS ACCOUNT CONTRIBUTIONS:**

| Total Annual Limit | 55+ Years Only | Employer Annual | Employee Annual | Per Pay |
|---|---|---|---|---|
| Single $3600.00 | Add'l $1,000 | $1272.00 | $ _____ | $_____ |
| Family $7200.00 | Add'l $1,000 | $3600.00 | $ _____ | $ _____ |

**PARTICIPANT AUTHORIZATION:**
I hereby authorize my employer to deduct from my salary, the required contributions for the amounts I have elected above. I agree to comply with the terms and conditions of the plan. I have read all the authorizations and acknowledgements provided below.

**SIGNATURE: _____ DATE: _____**

**H.S.A. – Acknowledgement and Authorization:**

I understand that an H.S.A. is an individually owned account and I am solely responsible for any tax implications as a result of failing to follow IRS rules and regulations outlined in IRS code Section 223.

I agree to have the amount elected on the form pre-taxed from my paycheck on a per payroll basis.

I have read and understand that H.S.A. guidelines and rules and confirm that I am eligible to participate in this benefit.

I understand that I am required to save all receipts for benefit card purchases in case I should be audited by the IRS.

I hereby understand the information on this form and authorize Milford EVSD to complete my request.