HEALTH SAVINGS ACCOUNT

ENROLLMENT & PAYROLL DEDUCTION AUTHORIZATION

Plan Year 1/1/2023 through 12/31/2023

Effective Date 1/1/2023

Employee Name: _____

Employee City ID Number: _____

Driver's License Number: _____ *(New HSA account only)*

I want to contribute a total of $_____ during this Plan Year to my Health Savings Account. I understand this amount will be deducted from my pay throughout the Plan Year.

Important Notice: Your medical FSA or VEBA is limited and can only reimburse dental and vision expenses.

Signature
I have reviewed the above election and understand my choices will remain in effect for the entire Plan Year unless I request a change (changes can be made up to once a quarter).

_____ _____
Signature Date

2023 Maximum Annual Contribution Levels

- Individual $3,850 (City contributes $2,400)
- Family $7,750 (City contributes $4,000)
- Additional "Catch up" amount for age 55+ account holders is $1,000