2024 Health Savings Account Change Form

Employee # _____

Name_____

Address_____

City, State, Zip_____

Health Savings Account:

☐ Health Savings Account: January 1st to December 31st
Annual Contributions Max: $4,150 single, $8,300 family
Employees age 55+ can contribute an additional $1,000

$_____ Annual Plan Year Total (less employer contribution)

Employer annual contribution $312.50 single / $625 family
Prorated with mid-year enrollments in the HDP and LPHDP medical plans

☐ Waive Health Savings Account contributions

Authorization

I have reviewed the terms of Consolidated Communications' Health Savings Account. I understand that the amount that I elect will be deducted from my paycheck on a pre-tax basis. I have read and agree to the terms of participation.

_____ _____
Employee Signature Date

Return Form to HR Services:
HRServices@consolidated.com
936.756.2822 (fax)

For Employer Use Only

Co. Code / Pay Group	Entered in PS	Initial