Health Savings Account Contribution Form

Name _____ Empl ID (7-digits) _____

Campus Email _____ Campus Phone _____

Health Savings Account Participation (only available to employees enrolled in the High Deductible Health Plan)

☐ **I elect to establish/continue a Health Savings Account (HSA).**
Complete the below Salary Reduction, the HSA Agreement, and Certification sections.

☐ **I elect NOT to continue an HSA.**
Sign and date the below Certification section.

Salary Reduction

2027 Annual HSA Contributions	
Coverage type	IRS Maximum Annual Contribution Limits
Self-only	$4,500
Family	$9,000
Catch-up Contribution if age 55+	$1,000

Total Annual Amount*		**Year to Date contributions (if any)**		**Number of pay periods to distribute**		**Per-pay period withholding**
_____	-	_____	/	_____	=	_____

*Total amount for the calendar year **Begin Date:** _____

Other, include direction and start and stop dates (ex. One time, two-month change)**:**

HSA Agreement

I authorize Case Western Reserve University to reduce my basic salary or end contributions, effective as indicated by the date listed above. Such salary reduction amount will be applied by CWRU to an HSA set up in conjunction with a qualified high deductible health plan. I acknowledge that this Agreement is subject to the conditions listed below. I acknowledge that this Agreement remains in effect unless terminated by me upon 30 days' written notice, my CWRU employment terminates, or my HSA bank account is inactivated.

☐ I understand it is my responsibility to manage my contributions per federal guidelines based on my eligibility, as well as my dependents.

☐ I understand using HSA funds for expenses other than those deemed qualified may be subject to tax and penalties, per the IRS.

Employee Signature _____ **Date** _____

Benefits Administration Use Only:
Effective Date Received by: Date

CASE WESTERN RESERVE UNIVERSITY
Department of Human Resources

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