TOWN OF HOLLISTON
HEALTH SAVINGS ACCOUNT (HSA)
PAYROLL DEDUCTION FORM

Plan Year: July 1, 2024– June 30, 2025

GENERAL INFORMATION:

Employee Name:_____

Mailing Address: _____

City:_____ State:_____ Zip: _____

E-mail Address: _____

Social Security # :_____ Date of Birth (mm/dd/yyyy): _____

Phone Number:_____

Date of Hire (mm/dd/yyy): _____

Please note that if you become ineligible for an HSA any time during the remainder of calendar year 2024 or if you are changing from a family plan to an individual plan or vice versa, please visit Human Resources as soon as possible to avoid IRS penalties.

Annual Limit for Individual Health Plan - $3,150
Annual Limit for Family Health Plan - $6,300

	Pay Schedule	Per Pay Period Deduction
Health Savings Account	☐ weekly ☐ bi-weekly ☐ monthly	_____

_____ _____
Employee Signature Date

Please return this form to Human Resources by Noon on Friday, May 10, 2024.

Health savings accounts are subject to IRS regulations and penalties. If you should become ineligible for an HSA during the year or your marital status changes, please visit Human Resources as soon as possible. It is the responsibility of the employee to notify the Town of any changes that effect your health care coverage and HSA contribution limits.