

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

Plan Year: July 1, 2021 – June 30, 2022

GENERAL INFORMATION:

Employee Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
E-mail Address: _____
Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____
Phone Number: _____
Date of Hire (MM/DD/YYYY): _____

Please note that if you become ineligible for an HSA any time during the remainder of calendar year 2021 or if you are changing from a family plan to an individual plan or vice versa please visit the Treasurer's Office as soon as possible to avoid IRS penalties.

	Pay Schedule	Per Pay Period Deduction
Health Savings Account	<input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly	_____

Employee Signature

Date

Please return this form to the Treasurer's by Noon on Friday, May 21, 2021.

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 the Treasurer's Office as soon as possible. It is the responsibility of the employee to notify the Treasurer's Office of any changes that effect your health care coverage and HSA contribution limi