

OPTUM HSA SALARY REDUCTION FORM

EMPLOYEE INFORMATION:

Employee:	Last Name:	First Name:	
SSN:		Date of Birth:	
Street Address:			
City:		State:	Zip
Phone #		Email:	

INSURANCE PLAN:

Insurance Plan:	Kaiser High Deductible HMO		
	<i>Circle one:</i>	Single Deductible	Family Deductible
Insurance Plan:	Sutter Health Plus High Deductible HMO		
	<i>Circle one:</i>	Single Deductible	Family Deductible
Insurance Plan:	Western Health Advantage High Deductible HMO		
	<i>Circle one:</i>	Single Deductible	Family Deductible
Insurance Plan:	Out-of-Area – Blue Shield High Deductible PPO		
	<i>Circle one:</i>	Single Deductible	Family Deductible

CONTRIBUTIONS TO ACCOUNT: EFFECTIVE DATE: _____

Monthly Payroll Contribution:	\$	Catch up Contribution ** Included: <i>Circle One</i> Yes No \$ _____
Total Annual Contribution	\$	

2020 Contribution Limits: \$3,550/single coverage or \$7,100/family coverage

***A Catch-Up Contribution of up to \$1000 is allowed for account holders who are age 55 years or older during the 2020 calendar year.*

I do hereby authorize my employer to deduct the stated amount from my pay warrant and deposit it into the custodial account with Optum Bank.

Employee Signature

Date

District Approval

Date