



# Health Savings Account (HSA) Contribution Change Form

Complete this form to make a mid-year change to your Health Savings Account annual contribution amount. Return form to Human Resources at [HumanResources@lakesideindustries.com](mailto:HumanResources@lakesideindustries.com) or fax 425-313-2614.

## Employee Information

Employee Name (Last, First, MI): \_\_\_\_\_ Employee Number: \_\_\_\_\_

Medical Coverage (check one):  Employee  Family\*

\*Family coverage includes Employee w/Spouse, Employee w/Child(ren), and Family HDHP coverage levels.

## Contribution Information

You may not reduce your annual amount below what you have contributed to date as refunds are not an option. The annual contribution must be an amount below the maximum as described below.

**Maximum** annual contribution (Limits shown below are less Lakeside’s \$1,000 Employee Only or \$1,500 Family contribution).

<u>Under age 55:</u>	<u>Age 55 or older (includes \$1,000 catch-up):</u>
Employee-only HDHP.....\$2,600	Employee-only HDHP.....\$3,600
Family HDHP* .....\$5,700	Family HDHP* .....\$6,700

\*Family coverage includes Employee w/Spouse, Employee w/Child(ren), and Family HDHP coverage levels.

## Action Request

**CHANGE** Health Savings Account Contributions  
Enter your updated 2021 Bi-weekly per paycheck contribution amount \$ \_\_\_\_\_

**STOP** Health Savings Account Contributions *(Please select one of the following):*

- I would like to stop all payroll deductions to my HSA at this time
- I am no longer an eligible individual to make contributions to a “Health Savings Account” (HSA) as of \_\_\_\_\_ (date)

## Employee Authorization

I authorize Lakeside Industries, Inc. to withhold contributions for this plan from my pay on a pre-tax basis. The contributions changes will take effect on the next pay period.

## Signature and Date

By checking this box and typing my name below, it is my intent to electronically sign and electronically submit this form. I understand that by checking this box and typing my name below, I will be applying my electronic signature to this form and that I will be bound with the same force and effect as if I had signed this form on paper by hand.

Employee Name \_\_\_\_\_ Date \_\_\_\_\_

<b>HR/PAYROLL USE ONLY:</b>	
Date Received _____	Date Entered _____
YTD ER Contributions \$ _____	YTD EE Contributions \$ _____
Remaining YTD eligible contributions \$ _____	