## STATE OF NEW JERSEY DIVISION OF PENSIONS AND BENEFITS STATE HEALTH BENEFITS PROGRAM — SCHOOL EMPLOYEES' HEALTH BENEFITS PROGRAM

## **HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM**

EMPLOYEE INFORMATION			
Employee Name:			
	Last	First	Middle Initial
Social Security Number:		Location Number:	Date:
PAYROLL REQUEST			
	n the date my HS	avings Account (HSA) contributions A medical plan will become effective	
Contributions are subject to for Employer contributions to you		al limits for 2013: \$3,250 for individund the annual limit.	uals; \$6,450 for families. Note:
Additional allowable contribut	ions for individuals	s between the ages of 55 - 65: \$1,00	00 for the account holder only.
Please fill in the desired amo	unt below.		
Per Pay:			
Contributions will begin after provider.	your HSA bank ac	count has been opened with the ba	nking institution selected by your
☐ Cancel deductions for the He	alth Savings Acco	unt from my paycheck.	
HEALTH PLAN			
High Deductible Health Plan (H	DHP) (Choose on	e from below)	
☐ NJ DIRECT HD4000*		Aetna Value HD4000*	
☐ NJ DIRECT HD1500		Aetna Value HD1500	
* School Employees' Health Be HD4000.	nefits Plan memb	ers are not eligible to select NJ DIR	ECT HD4000 or Aetna Value
Coverage Level (Choose one fro	m below)		
☐ Single		Member and Spouse/Civil Union P	artner
☐ Member and Domestic P	artner $\Box$	Family	
☐ Parent and Child(ren)			
Employee Signature:			Date:

Please return the completed form with your enrollment application to your benefits administrator.