## Health Savings Account Change of Contribution Form

Name	
Campus Address	Campus Phone
Health Savings Account Participation (or	ly available to employees who enroll in the Anthem High Deductible Health Plan)
☐ I elect to establish/continue HSA Agreement below.	a Health Savings Account. Complete the remainder of this form and sign the
	ealth Savings Account. Sign the HSA Waiver below.
	make this election once per month for a maximum of four elections in a ount Agreement for annual contribution maximum.
I direct that this amount be contributed	on my behalf to my Health Savings Account.
the state of the s	
\$ /month beginning	<del>_</del>
Health Savings Account Agreement	
following the month in which this agreer Western Reserve to a Health Savings A	rersity to reduce my basic salary, effective as of the first day of the month ment is executed. Such salary reduction amount will be applied by Case account set up in conjunction with a qualified high deductible health plan. I bject to the conditions listed below. I understand that this Agreement will ing by me.
Employee Signature	Date
Employee Signature  Health Savings Account Waiver	Date
·	
Health Savings Account Waiver  I elect to stop my contributions to the H	
Health Savings Account Waiver  I elect to stop my contributions to the H	ealth Savings Account (HSA)
Health Savings Account Waiver  I elect to stop my contributions to the H	ealth Savings Account (HSA)
Health Savings Account Waiver  I elect to stop my contributions to the H End date	ealth Savings Account (HSA)
Health Savings Account Waiver  I elect to stop my contributions to the H End date  Benefits Administration Use Only  Effective Date	ealth Savings Account (HSA)  Employee Signature Date
Health Savings Account Waiver  I elect to stop my contributions to the H End date  Benefits Administration Use Only  Effective Date	ealth Savings Account (HSA)  Employee Signature Date  Received by Date  Health Savings Account Agreement
Health Savings Account Waiver  I elect to stop my contributions to the H End date  Benefits Administration Use Only  Effective Date  I acknowledge that this Agreement is saven	ealth Savings Account (HSA)  Employee Signature Date  Received by Date  Health Savings Account Agreement
Health Savings Account Waiver  I elect to stop my contributions to the H End date  Benefits Administration Use Only  Effective Date  I acknowledge that this Agreement is step of the II remains in effect unless terminated HSA bank account is inactivated.	ealth Savings Account (HSA)  Employee Signature Date  Received by Date  Health Savings Account Agreement ubject to the following conditions:

