



HSA Contribution Change Form

Date: ___/___/___

Employee Name: (print full name): _____

LFUCG Employee ID: _____

Current Contribution amount (per pay period): \$ _____

Change my Health Equity Health Savings Account deduction to this dollar amount:

Per pay period: \$ _____ **OR** Annual \$ _____

Beginning ___/___/___ pay date.

**Please note that it is the HSA account holder's responsibility to manage the annual contribution limits with respect to the IRS regulations.

**Contribution change forms must be submitted to the Benefits office via email, fax, or interoffice mail the week prior to the pay date it is to be deducted.

**A separate form must be completed for each change.

Employee's Signature

Date Submitted

