PULASKI COUNTY HSA PLAN
SALARY ADJUSTMENT AFFIDAVIT
JANUARY 1, 2019 TO DECEMBER 31, 2019

I, _____, SSN: _____
(Please Print)

_____
Mailing Address (including city, state, and zip code)

Email Address _____

Work Phone # _____ Home Phone # _____

an employee of the employer noted above, do hereby elect to participate in my employer's Health Savings Plan, I hereby authorize my employer to reduce my gross compensation each **SEMI-MONTHLY** pay period by an amount equal to the total of these expenditures.

2019 HSA Contribution Limits:
Individual - $
Family - $

Contributions January 2019 by Pulaski Co
Individual - $1,260
Family - $2,508

	Per Pay Period	Annual Election
HEALTH SAVINGS ACCOUNT CONTRIBUTION	$_____	$_____
TOTAL	$_____	$_____

I hereby certify that I have examined this Salary Adjustment Enrollment Form and to the best of my knowledge and belief, it is true, correct and complete.

_____ _____
Date **Signature**

Please notify Health Savings Administrators if you have a change of address.