PULASKI COUNTY HSA PLAN
SALARY ADJUSTMENT AFFIDAVIT
JULY 1, 2018 TO DECEMBER 31, 2018

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.

2018 HSA Contribution Limits:
Individual - $3,450
Family - $6,900

Contributions July 2018 by Pulaski County
Individual - $630
Family - $1,254

Before completing the following section, please consider the amount you have already contributed between January 1, 2018 to May 15, 2018 and the amount the County will be contributing in July 2018. You will be penalized by the IRS if you exceed the maximum allowed contribution.

	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.