

**PULASKI COUNTY HSA PLAN
SALARY ADJUSTMENT AFFIDAVIT
JANUARY 1, 2021 TO DECEMBER 31, 2021**

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.

2021 HSA Contribution Limits:

Individual - \$3,600

Family - \$7,200

Ages 55 or older catch up provision:

Extra \$1,000 per year

Contributions January 2021 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 be sure to notify Health Savings Administrators if you have a change of address.