

**2024 HEALTH SAVINGS ACCOUNT
EMPLOYEE CONTRIBUTION ELECTION
FORM**

(To be completed and returned to your employer)

Employer Name: St. Charles ISD

ACCOUNT OWNER'S NAME AND ADDRESS:

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Last Name

First Name

Middle Initial

Street Address

City

State

Zip Code

Social Security No.

Daytime Phone

Evening Phone

CONTRIBUTIONS

 I wish to contribute \$ to my HSA account each pay period on a pre-tax basis.
This is for the 2024 calendar year.

 I wish to make a single contribution of \$ to my HSA account on a pre-tax
basis. I understand this will be deducted from my paycheck one time only for the tax year
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SIGNATURE

It is my responsibility to determine whether I am eligible to make contributions to my HSA, and
to determine whether contributions to this HSA have exceeded the applicable maximum annual
contribution limit.

Account Owner

Date