



**OPTUM HSA SALARY REDUCTION FORM**

**EMPLOYEE INFORMATION:**

Employee:	Last Name:	First Name:	
SSN:		Date of Birth:	
Street Address:			
City:		State:	Zip
Phone #		Email:	

**INSURANCE PLAN:**

Insurance Plan:	Kaiser High Deductible HMO
	<b>Circle one:</b> Single Deductible    Family Deductible
Insurance Plan:	Sutter Health Plus High Deductible HMO
	<b>Circle one:</b> Single Deductible    Family Deductible
Insurance Plan:	Western Health Advantage High Deductible HMO
	<b>Circle one:</b> Single Deductible    Family Deductible
Insurance Plan:	Out-of-Area – Blue Shield High Deductible PPO
	<b>Circle one:</b> Single Deductible    Family Deductible

**CONTRIBUTIONS TO ACCOUNT: EFFECTIVE DATE: \_\_\_\_\_**

Monthly Payroll Contribution:	\$ _____	Catch up Contribution ** Included: <b>Circle One</b> Yes    No \$ _____
Total Annual Contribution	\$ _____	

**2020 Contribution Limits: \$3,550/single coverage or \$7,100/family coverage**

\*\*A Catch-Up Contribution of up to \$1000 during the 2020 calendar year is allowed for account holders who are over 55 years of age.

I do hereby authorize my employer to deduct the stated amount from my pay warrant and deposit it into the custodial account with Optum Bank.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
District Approval

\_\_\_\_\_  
Date