



State of New Jersey • Division of Pensions & Benefits (NJDPB)
 State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)
HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION FORM
For State Centralized Payroll Employees

EMPLOYEE INFORMATION

Employee Name: _____
Last First Middle Initial

Social Security Number: _____ Payroll Number: _____ Date: ____/____/____

PAYROLL REQUEST

I authorize my employer to deduct the Health Savings Account (HSA) contribution identified below on a pre-tax basis beginning no earlier than the date my HSA medical plan will become effective. The funds are eligible to be deposited into my Health Savings Account.

Contributions are subject to federal limits. Annual limits for 2020: \$3,550 for individuals; \$7,100 for families.

Note: Employer contributions to your HSA count toward the annual limit.

Additional allowable contributions for individuals between the ages of 55 - 65: \$1,000 for the account holder only.

Please fill in the desired amount below.

Per Pay Period: _____

Contributions will begin after your HSA bank account has been opened with the banking institution selected by your provider.

Cancel deductions for the Health Savings Account from my paycheck.

HEALTH PLAN

High Deductible Health Plan (HDHP) Check one box only.

- NJ DIRECT HD1500 NJ DIRECT HD4000

Coverage Level Check one box only.

- | | |
|--|--|
| <input type="checkbox"/> Single | <input type="checkbox"/> Member and Spouse/Civil Union Partner |
| <input type="checkbox"/> Family | <input type="checkbox"/> Member and Domestic Partner |
| <input type="checkbox"/> Parent and Child(ren) | |

Employee Signature: _____ **Date:** ____/____/____

Please return the completed form to: N.J. Department of the Treasury
 OMB – Centralized Payroll
 P.O. Box 207
 33 W. State Street, 2nd Floor
 Trenton, NJ 08625-0207