

**SHELBYVILLE CENTRAL SCHOOL CORPORATION
HEALTH SAVINGS ACCOUNT**

HEALTH SAVINGS ACCOUNT ELECTION FORM

Name (please print)

Address: _____

City, State, Zip _____

Social Security Number _____

Location _____ Job Classification _____

Please reduce my earnings for 2023 sufficient to fund the following Health Savings Account:

\$ _____

(Maximum: \$3,850 per year for single plan and \$7,750 per year for family plan)

I authorize the company to reduce my annual earnings by the amounts indicated for the Health Savings Account listed above. This reduction will take the form of payroll deductions from my regular paychecks, when those paychecks are sufficient to permit a deduction. If my pay in any pay period is insufficient to allow a full deduction, a partial deduction may be made.

I realize that this authorization is irrevocable, and that I will be allowed to change the amount deducted only if there is a change in my family circumstances, specifically, the gain or loss of a dependent or my spouse's loss or change of employment.

Signed: _____

Date: _____