State of Arizona – Benefit Options
2016 HSA Payroll Deduction Authorization

Please Print or Type

Name (Last, First, MI)	Employee ID Number
Street Address	Phone Number
City, State, Zip	Date of Birth
Agency	Date of Hire

MAXIMUM HSA CONTRIBUTION

Every year the Internal Revenue Service (IRS) sets maximum contribution limits for health savings accounts (HSAs). Failure to observe these limits may result in tax penalties. PayFlex is required to report HSA contribution information to the IRS. There are other contribution schemes but the maximum per payday will generally prevent an account holder from over contributing to their HSA. For additional information on Maximum HSA Contributions visit BenefitOptions.az.gov.

HSA Contribution			
Coverage Type	**State Contribution**	**Employee Annual Contribution Maximum**	**Annual IRS Contribution Maximum**
Employee	$27.69 per pay period Up to $719.94 annually[1]	$2,630.06	$3,350.00
Employee + Adult	$55.38 per pay period Up to $1,439.88 annually[1]	$5,310.12	$6,750.00
Employee + Child	$55.38 per pay period Up to $1,439.88 annually[1]	$5,310.12	$6,750.00
Family	$55.38 per pay period Up to $1,439.88 annually[1]	$5,310.12	$6,750.00

[1]Subject to effective date of enrollment and remaining pay periods.

Tier	
☐ Employee only ☐ Employee+Adult ☐ Employee+Child ☐ Family	I elect a per pay period HSA contribution of $_______________________ Payroll contributions for HSAs are taken pre-tax. This authorization will remain in effect until a new authorization is received.
	Effective date: Pay period beginning ___________________ (mm/dd/yyyy) End date: Pay period ending __________________________ (mm/dd/yyyy)

I am enrolled in the State of Arizona's HSA Plan and have no other medical coverage, including Medicare. I am eligible to open and contribute to a health savings account. I hereby request and authorize the State of Arizona to deduct from my pay the above-identified deduction and to forward it to my health savings account with PayFlex. I understand it is my responsibility to manage my contributions in accordance with federal guidelines based on my eligibility as well as my dependents. I also understand that using my HSA funds for expenses other than those deemed qualified may subject me to tax penalties.

Employee's signature ____ **Date** ____________________

Return this form to your agency liaison or ADOA Benefit Services Division at 100 N. 15th Ave., Suite 260, Phoenix, AZ 85007.