

**Section 1: Member Information**

LAST NAME		FIRST NAME		M.I.
EMPLOYEE ID NUMBER (EIN)	SOCIAL SECURITY NUMBER (REQUIRED)	BIRTH DATE	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
STREET		CITY	ZIP	AGENCY
HOME PHONE	CELL PHONE	EMAIL		

**Section 2: Cancel Employer Contribution**

PLEASE NOTE: The purpose of this form is to stop the employer portion of your bi-weekly HSA contributions. To stop your employee contribution from your paycheck, see "Employee Contribution Cancellation Acknowledgement" below.

**REASON FOR REQUEST**

<input type="checkbox"/> I am ineligible for an HSA because: <input type="checkbox"/> I am eligible for Medicare <input type="checkbox"/> I am covered by TriCare <input type="checkbox"/> I am receiving benefits from the Veterans Administration <input type="checkbox"/> I am being claimed as a dependent on another person's tax return <input type="checkbox"/> I am covered by my spouse's medical plan	<input type="checkbox"/> I have exceeded my annual contribution limits. <input type="checkbox"/> Other:
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**AUTHORIZATION**

I am enrolled in the State of Arizona's HSA Plan. I understand it is my responsibility to manage my contributions in accordance with federal guidelines based on my eligibility as well as that of my dependents.

I hereby request and authorize the State of Arizona to stop the agency contribution sent to my health savings account with Optum Bank.

Paycheck Stop Date for Agency Contribution: \_\_\_\_\_  
*To see a paycheck schedule, visit [benefitoptions.az.gov/payrollcalendar](http://benefitoptions.az.gov/payrollcalendar)*

**Section 3: Employee Contribution Cancellation Acknowledgement**

I acknowledge that to stop my employee contribution from my paycheck, I must access [hrsystems.azdoa.gov](http://hrsystems.azdoa.gov) > Y.E.S Portal > Your Employee Services > Benefits > Elections > Health > Additional Contribution.

**Section 4: Signature**

PRINT NAME \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

*Return the form to your agency liaison or ADOA HR/Benefits at the contact information below.*

**ARIZONA DEPARTMENT OF ADMINISTRATION- HR/BENEFITS, PO BOX 6548, PHOENIX, AZ 85005**  
**EMAIL: [benefits@azdoa.gov](mailto:benefits@azdoa.gov) | PH: 602-542-5008 | TOLL-FREE: 1-800-304-3687 | FAX: 602-542-4744 | WEB: [benefitoptions.az.gov](http://benefitoptions.az.gov)**