STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

HEALTH SAVINGS ACCOUNT
Payroll Deduction Election Form

Plan Member Name: Last, First, Middle Initial | Social Security Number

Agency Name | Agency Number

I authorize the pre-tax reduction of my salary on a monthly basis by the amount designated below. I also understand that I may change my HSA salary reduction election once a month. If an election change is entered into eEnrollment between the first and fourteenth days of the month, the effective date will be the first of the next month. If the change is entered on or after the fifteenth of the month the effective date will be the first of the second month.

I understand that any withdrawals/distributions made from my HSA for health care expenses incurred prior to the establishment of my HSA or for other non-qualified types of expenses will be **taxable** and may be subject to additional penalties in accordance with IRS regulations. I further understand that it is solely my responsibility to report these withdrawals/distributions to the IRS.

Employee Signature | **Date**

Monthly Deduction

Revised 1/07/16 GB-79