

Accrue CMS

EMPLOYEE ENROLLMENT FORM

Company Name:		Name:			
Address:		City:	State:	Zip Code:	Hire Date:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number:		Email Address:	
Social Security Number:					

Note: **Contribution changes are only allowed with sufficient notice - Change requests must be submitted 10 days prior to your next payroll date**

Pay Period: (Check the box which indicates the frequency of your paychecks)

WEEKLY BI-WEEKLY SEMI-MONTHLY MONTHLY OTHER

Health Savings Account Annual Election

\$ _____ \$4,400 annual maximum for single coverage
\$8,750 annual maximum for family coverage
\$1,000 additional if over age 55

Per Pay Period Contribution

\$ _____

I decline to participate

I hereby authorize my election(s) for the benefit(s) designated above for the plan year. I understand that my pay will be reduced by the elected amounts. I understand that these elections are pre-tax and must be used according to IRS rules.

Employee Signature: _____ Date: _____