

Accrue CMS

EMPLOYEE ENROLLMENT FORM

Company Name:		Name:			
Address:		City:	State:	Zip Code:	Hire Date:
Date of Birth:	Gender: ☐ Male ☐ 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

\$

\$4,500 annual maximum for single coverage

\$9,000 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: _____