INDIANA UNIVERSITY

Health Savings Account
Enrollment, Change, Termination Form

Changes to your health savings account (HSA) can be made at any time during the year by submitting an Optional Benefit Change request through the Employee Center, or by submitting this form. Please only use one method to submit your elections.

- If you're enrolling or changing your contribution amount, enter your desired total annual contribution in Section 1 below.
- Each pay period, your contribution is calculated by subtracting contributions you've already made from your new annual election, then dividing the remaining balance by the number of pay periods left in the year (based on a 12-month schedule).
- If you wish to reduce, suspend, or stop making HSA contributions, your new annual contribution amount cannot be less than what you've already contributed. Refunds are not allowed, and your total pledge must fall within the plan's minimum and maximum limits.

Enter your annual contribution election below. Your annual contribution must be between $300 and the maximum listed in the table below. The maximum amount you can contribute depends on your level of coverage and age. If you will be age 55 or older in 2025, you can contribute up to $1,000 above the maximum each year (make a "catch-up contribution"). Maximums can also be affected by your spouse's HSA contributions, Archer MSA contributions, and/or the number of months you are covered under an HDHP. See the table below for specific limits.

IF YOU'RE UNDER AGE 55...	IRS limit:	IU contributes:	You can contribute up to:
Employee-only coverage	$4,300	$1,300	**$3,000**
All other coverage levels	$8,550	$2,600	**$5,950**

IF YOU'RE AGE 55 & OLDER...	IRS limit:	IU contributes:	You can contribute up to:	Plus the $1,000 catch-up, for a total of:
Employee-only coverage	$4,300	$1,300	$3,000	**$4,000**
All other coverage levels	$8,550	$2,600	$5,950	**$6,950**

SECTION 1—CHANGE REQUEST

☐ **ENROLL IN THE HSA. Open an HSA in my name and set my 2025 annual contribution to $_____.** I understand this amount will be divided equally over the remaining pay periods in the year. I certify that I meet the eligibility requirements for an HSA; authorize the plan vendor to open an HSA in your name and agree to the Custodial Agreement and Disclosure Statement, Electronic Disclosure, Important Information on Patriot Act Requirements, IU Benefit Card Terms and Conditions, and to the Schedule of Fees.

☐ **CHANGE MY HSA CONTRIBUTION AMOUNT. Change my 2025 annual contribution to $_____.** I understand this amount (minus any YTD contributions) will be divided equally over my remaining paychecks in the year.

☐ **SUSPEND OR STOP MY HSA CONTRIBUTIONS.**

- ☐ **Suspend my contributions.** I certify that I have contributed at least the $300 minimum annual contribution.
- ☐ **Stop my contributions.** I am no longer eligible for tax-free HSA contributions. I understand that my account will be transitioned to an individual account that is no longer associated with IU, and that I am now responsible for the monthly account maintenance fees.

SECTION 2—EMPLOYEE INFORMATION

Employee Name:		University 10-Digit ID:
Campus:	Department:	Phone:
Email:		
Medical Coverage Level: ☐ Employee Only ☐ Family*		Pay Cycle: ☐ Biweekly ☐ Monthly

Employee Authorization

I authorize IU to withhold my contributions for this plan from my pay on a pre-tax basis. The per-pay period contribution will be determined by subtracting my year-to-date payroll deductions from the new elected annual amount and dividing over the remaining pay periods for the year. This change will take effect on the next available paycheck date, as determined by payroll's processing schedule.

Signature:	Date:

**Family coverage includes Employee w/Spouse, Employee w/Child(ren), and Family coverage levels.*

Return this form to IU Human Resources at askhr@iu.edu or 2709 E. 10th Street, Ste 321, Bloomington, IN 47408.

HR USE ONLY
DATE RECEIVED: _____ ENTERED BY: _____ DATE ENTERED: _____