AMERICAN BENEFITS GROUP

HSA ENROLLMENT FORM

First Name: _____ Last Name: _____

Date of Birth:_____SSN: _____

Street Address: _____

City:_____State:_____Zip Code: _____

Email:_____Phone: _____

Employer: _____ Division: _____

Depending on what your High Deductible Health Plan coverage is you have the following annual limits. These limits are the total contributions you can make in your HSA including any Employer contribution.

2024	**Individual:** $4,150	**Family:** $8,300	**Catch-up Contribution** (55 or Older): $1,000
2025	**Individual:** $4,300	**Family:** $8,550	**Catch-up Contribution** (55 or Older): $1,000

Per Pay Period Contribution: _____

I hereby authorize my employer to reduce my salary (on a pre-tax basis) by the amount necessary to pay for the coverages indicated above.

Employee Signature: _____ Date:_____

Submit this form to your HR Department

If you have any questions on how to complete this form,
call American Benefits Group at 800-499-3539 or email support@amben.com

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EMPLOYER PLEASE COMPLETE:

Effective Date: _____ ☐ Individual ☐ Family

Employer Signature: _____ Date:_____

Fax: 877-723-0147 or email: processing@amben.com

American Benefits Group | PO Box 1209, Northampton, MA 01061-1209 | 800-499-3539