

# Contra Costa County Kaiser Permanente Health Savings Account (HSA) Contribution Change Request

Employee Name	Social Security Number <b>XXX-XX-</b>	Employee Number
Mailing Address		
Work Phone	Home/Cell Phone	Email Address

Effective Pay Date \_\_\_\_ / 10 / 20 \_\_\_\_

(Example: 4/10/YYYY Check Date is for Pay End Date 3/31/YYYY)

From: Current Monthly Contribution Amount: \_\_\_\_\_

To: New Monthly Contribution Amount: \_\_\_\_\_

Annual Federal Contribution Limits: Individual - \$3,550 and Family - \$7,100 (Employees 55 or older may contribute an additional \$1,000 per year)

Please note change form must be received by Employee Benefits Service Unit by the 25<sup>th</sup> of the month to be processed for the next 10<sup>th</sup> of the month pay.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Return this form to Employee Benefits Service Unit  
651 Pine Street, 5<sup>th</sup> Floor, Martinez, CA 94553  
Fax: 925-335-1798 / Email: [benefits@hrd.cccounty.us](mailto:benefits@hrd.cccounty.us)