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

Employee Name	Social Security Number XXX-XX-		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 - $3,650 and Family - $7,300 (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 25th of the month to be processed for the next 10th of the month pay.

________________________________ ______________________________

Employee Signature Date

Return this form to Employee Benefits Service Unit
1025 Escobar St., 2nd Floor, Martinez, CA 94553
Fax: (925) 655-2199 / Email: benefits@hrd.cccounty.us