

H S A /VEBA Contribution Election Form

Employer: Arrowhead Economic Opportunity Agency

Account Owners's Name/and Address

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Daytime phone: _____ Evening Phone: _____

Contributions

I wish to contribute \$_____ to my H S A account each pay period on a pre-tax basis. I understand that this amount will be deducted from my paycheck until I indicate otherwise.

Employer Election – Check the option you are selecting for your Employer Contribution

Health Savings Account _____ 100 Percent

VEBA _____ 100 Percent

Health Savings/VEBA _____ 50/50 Split

Signature

It is my responsibility (1) to determine whether I am eligible to make contributions to my H S A, and (2) to determine whether contributions to this H S A have exceeded the applicable maximum annual contribution limit.

Account Owner

Date