Health Savings Account (HSA)
Employee Enrollment Form

HealthEquity
Building Health Savings℠

Inter School Mail or fax completed forms to:
Dawn Schaller, Assistant Director HR-Benefits
Board Office **Fax:** 734-416-2089

EFFECTIVE 1-1-2025 – 8-31-2025

Employer Information

Employer Name
PLYMOUTH CANTON COMMUNITY SCHOOLS

Account Holder Information

First Name	M.I.	Last Name	
SSN	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	
E-mail Address		Home Phone ( )	
Physical Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP

Elections:

Health Savings Account 2025 Annual Maximum $4,300 Single - $8,550 Family	Contribution Per Pay Period	Number of Pay Periods Remaining in Plan Year		Your Annual Election Amount
Health Savings Account (HSA Election) Must be enrolled in Health Plan 7 or 8 to qualify for this account.	$	X 12 pays	=	$

Contribution Per Pay Period x Number of Pay Periods = Your Election Amount

I authorize the reduction of my salary (on a per paycheck basis) for contributions to my Health Care Reimbursement Account and/or Dependent Care Reimbursement Account. I understand that such deductions will be made on a pretax basis. I also understand that this authorization is irrevocable until the next plan year, unless I have a change in family status (i.e., marriage, divorce, birth or adoption of a child, etc.). THE EMPLOYEE BENEFITS OFFICE MUST BE NOTIFIED WITHIN 30 DAYS OF THE FAMILY STATUS CHANGE.

Signature

Print Name	Signature	Date