Desert Sands Unified School District
BLUE SHIELD High Deductible Health Plan (HDHP)
Health Savings Account (HSA)
Salary Reduction Agreement

Type of Agreement:

- ☐ NEW agreement

OR

- ☐ Superseding/changing an existing agreement

(may only be changed once per fiscal year)

Type of funding received by District:

- ☐ - Single
- ☐ - Family
- ☐ - Joint (Married DSUSD employees w/one Account)

In accordance with Education Code Sections 44041 and 87040, Government Code Sections 1157 and 53200 et seq. and for the purpose of qualifying under the provision and for the benefits of the Blue Shield PPO Health Savings Account (Plan) of the Internal Revenue Code, and Section 17501 et al of the California Revenue and Taxation Code:

IT IS HEREBY AGREED BY THE DISTRICT AND:

Employee Type: ☐ - Certificated ☐ - Management **Employee #:**____________

Employee Name:____ **Last 4 Digits SS#:**_______

Site/Department:____

(hereinafter called the Employee) that the certain valid and existing employment contract made and entered into by and between the District and Employee be amended in the following manner and that this amendment be incorporated therein by reference and made a part of thereof as if set out therein in full, as of the date of this amendment:

Compensation to be paid to this Employee by the District shall be reduced "Pre-Tax" by the amount indicated per pay period starting with the compensation to be paid on the date stated, but shall not be effective for compensation already paid. Employee is solely responsible for not exceeding maximum contributions allowed by the IRS:

IRS 2019 Calendar Year Maximum HSA Contribution Limits:

The IRS calendar year limits listed below **include the **District calendar year** HSA **contribution** amounts.

Single: **$3,500** **Family:** **$7,000**

Amount of each **TENTHLY** deduction **"Pre-Tax"** $_______________ Galaxy Code – **8658**

START Date of "Pre-Tax" deductions: ____/____/____ **END DATE** of Pre-Tax deductions: 06/30/19

I, the undersigned employee, authorize the identified amount listed above to be deposited into my BenefitWallet Health Savings Account and accept full responsibility for any penalty incurred for exceeding IRS maximum contribution limits.

____________________________________ ________________

Employee Signature **Date**