UNIVERSITY OF VIRGINIA
HEALTH SAVINGS ACCOUNT (HSA) PROGRAM
EMPLOYEE CONTRIBUTION CHANGE FORM

MEDICAL CENTER EMPLOYEES ONLY
Note: Academic Division Employees must submit requests for changes using Benefits@. This form is for Medical Center employees only.

Use this form to request a change to the amount of your annual election. Submit this form to the University Human Resources (UHR) Benefits Division by one of the following contact methods:

Email: AskHR@Virginia.edu
-OR-
FAX: 434-924-4486
-OR-
Mailing/Interoffice Address:
University Human Resources
Attn: UHR Benefits Office
914 Emmet St. Box 400127
Charlottesville, VA 22904

Employee Name ____________________________ Employee # __________________

Effective date of this change will be the 1st day of the month following receipt of your form at the UHR Benefits Office. Please note your new annual election request cannot be less than the amount you have already contributed to your Health Savings Account during the current calendar year (you can look at your year-to-date HSA contribution total from your paycheck to confirm that amount).

Election Change Options (check one):

______ Cease further employee contributions to the Health Savings Account Program

______ Change the Annual Election as shown below. The new annual election cannot be less than the amount already contributed to your Health Savings Account during the current calendar year.

<table>
<thead>
<tr>
<th>Previous Annual Election</th>
<th>New Annual Election</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Savings Account Employee</td>
<td>$___________</td>
</tr>
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</table>

I have read and fully understand the regulations to change my election. I understand that retroactive election changes and HSA refunds are not allowed and that my election change will be effective on the 1st of the month following receipt of this form at the UHR Benefits Division.

Requested by:
Participant Signature ____________________________ Date: __________________

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FOR UHR BENEFITS DIVISION USE ONLY
Reviewed and Approved by:
UHR Benefits Division Representative Signature ____________________________________________
Date Received: __________________ Date Processed: __________________