

AUTHORIZATION FOR HEALTH SAVINGS ACCOUNT (HSA)

Company: _____

Employee Name: _____

I hereby authorize my employer to initiate credit entries and to initiate if necessary, debt entries and adjustments for any credit entries in error to my (our) account listed below.

Name of bank

Routing & Transit Number

Account Number

PLEASE ATTACH A COPY OF A
VOIDED CHECK

TYPE OF HSA (Please check one only):

Single Family

EMPLOYEE CONTRIBUTION PER CHECK \$ _____

EMPLOYER CONTRIBUTION PER CHECK \$ _____
(Employer contributions are not required and are at the discretion of each employer)

This authority is to remain in full force and effect until the Employer has received written notification from me of its termination in such time and manner as to afford Employer a reasonable opportunity to act on it.

EMPLOYEE SIGNATURE _____ DATE _____

To insure this pretax HSA information has been authorized by your employer, please return this form to your HR manager or Payroll Administrator for approval.

AUTHORIZED BY _____ DATE _____
(Employer)

****IF YOU CLOSE OR CHANGE YOUR BANK ACCOUNT, PLEASE NOTIFY ASAP AT 970-728-6777****

Please return this form and any attachments to our payroll staff.

payroll@businessASAP.com Fax: 970.728.6848 Phone: 877-728-6777

All forms are available for download at www.businessASAP.com