Employee Direct Deposit Authorization Agreement – Health Savings Account

Client Number: _____ Company Name: _____

I hereby authorize my employer, _____ (hereinafter COMPANY) to deposit any amount owed me by initiating credit entries to my account at the financial institution (hereinafter BANK) indicated below. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY deposits funds erroneously into my account, I authorize COMPANY to debit my account for an amount not to exceed the original amount of the erroneous credit.

Employee Information:

Employee Name (Please print): _____

Employee Social Security Number: _____-_____-_____

Type of Request (Please check as applicable and indicate effective date as requested):

_____ Begin Deposit effective ___/____/____

_____ Change Information effective ___/____/____

_____ Cancel Deposit effective___/____/____

_____ Single Plan _____ Family Plan

Bank Name: _____

Health Savings Account Number: _____

(Attach a voided check or deposit slip.)

I wish to deposit: $ _____.00 per pay period into my Health Savings Account.

This authorization is to remain in full force and effect until COMPANY and BANK have received written notice from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it.

Employee Signature: _____ Date: ___/____/____