HSA Payroll Deduction Form

Full Name _____

Employee ID#_____

Building Job Title:_____

SHAWNEE MISSION SCHOOL DISTRICT

I am paid monthly and want _____

Deducted from my check monthly and deposited into my HSA

Effective Date _____

Return this form to the Benefits Office to complete the change.

Fax: 913-993-6283

E-mail: Benefits@smsd.org

I am paid biweekly and want _____

Deducted from each of my biweekly checks and deposited into my HSA

Effective Date _____

*Requests received by the 15th of the month will be processed on the first day of the pay period of the next month

Employee Signature _____ **Date** _____

For Benefit and Payroll use only

Benefits Signature _____ Date _____

Payroll Signature _____ Date _____

Over 55 Yes NO