Darien Board of Education
35 Leroy Avenue
Darien, CT 06820
Phone: 203-656-7404
Fax: 203-656-3052

PAYROLL HSA DEDUCTION FORM

Employee Name (Please Print):

New Account _____Change Deduction _____Stop Deduction_____

Bank Routing Number: **ON FILE**

Account #: **ON FILE**

Amount: $

Date to Begin Deduction:

By signing below I am authorizing the Darien Board of Education to make payroll deductions in the amount specified above. This amount will be applied as a contribution to my HSA Account under the Board of Education's Medical Insurance HSA Plan. I will inform the Board of Education in writing when I wish to alter or terminate this authorization. I also agree that the Board of Education may stop this deduction if it determines that I am no longer eligible to make these contributions.

This form must be returned to the Payroll Department at least 7 business days prior to the pay distribution date to process the HSA deduction.

Employee Signature: _____

Date: _____