HEALTH SAVINGS ACCOUNT

PAYROLL CONTRIBUTION ELECTION FORM

□ Change Contribution Amount

□ Stop Contribution Amount

By signing this form, I authorize my employer to deduct, stop or change the elected amount from my pay on each pay date. I hereby consent that all personal information and selections made are correct.

_____ _____

Signature Date signed

_____

LAST NAME FIRST NAME MI EMP ID# (S S #)

_____

COMPLETE MAILING ADDRESS (Include city, state,zip)

_____

DATE OF BIRTH DATE OF EMPLOYMENT HOME PHONE

I elect to have the following amount deducted **per pay period $**_____ ***** **(This amount is withheld over 24 pays)**

Start Date :_____ **Stop Date**: _____

I understand this deduction will not change unless I change my election by submitting a new HSA payroll Deduction Form to begin the 1st day of the next month.