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