Douglas County
SCHOOL DISTRICT

HSA Payroll Contribution Form

Last Name, First Name			Employee SSN
Address	City	St	Zip
Email	DOB (MM-DD-YYYY)	☐ New Enrollee ☐ Renewal Enrollment	OFFICE USE ONLY Effective Date

HSA ACCOUNT – THIS BENEFIT IS SUPPORTED BY BANK OF AMERICA

I request the following amount to be reduced from my paycheck:

Benefit	Yes/No	Annual Election	No. of Paychecks	Paycheck Deduction
HSA	☐ Yes ☐ No	$______ per plan year	12	$______ per paycheck

PREMIUM AGREEMENT FOR HEATH SAVINGS ACCOUNT

Please check one:

- ☐ I elect to participate in the HSA. *Please read the following and sign below.*
- ☐ I decline participation in the HSA. *Do not sign below.*

I agree to have my employer deduct pre-tax payroll contributions to fund my Health Savings Account. I understand that if my employment is terminated prior to the end of the Plan Year, the company will no longer absorb the administrative costs associated with the account. Contributions will be taken from my final paycheck on a pre-tax basis.

Signature: ____________________ Date: __________

Sign here *only* if you are participating in the Health Savings Account

AUTHORIZATION

I hereby certify the above information to be correct and true to the best of my knowledge. I understand that the above reductions may correspondingly reduce my future Social Security benefits. My signature on this form certifies that I have received and read the materials explaining the Health Savings Account program.

Signature: ____________________ Date: __________

OFFICE USE ONLY

Direct Deposit Pre-Tax Payroll	☐ Yes ☐ No	HSA Account Information Routing # 053201610 Account #