Blue Cross Blue Shield of Rhode Island

Health Savings Account
Employee Contribution Authorization Form

Employee Information:

Employer/Company Name:		
First Name:	Last Name:	
Street Address:		
City:	State:	Zip Code:
Date of Birth:		

Employee's HSA Contribution Per Pay Deduction/Allocation:

	Annual HSA Amount	**# of Payrolls**	**Per Payroll Amount**
Employee HSA Contribution:	$_____	divided by _____	= $ _____

Additional debit card requests for tax-dependents can be requested through:

Michael Weaver, Senior Account Manager
London Health Administrators, Ltd.
40 Commercial Way
East Providence, RI 02914
401-435-4700, Ext. 227
michael.weaver@floreshr.com

I Understand That:

(1) I agree to have my compensation reduced by the deduction amount(s) stated above. I further understand that the Health Savings Account deduction will be in effect until my participation in the HSA is terminated.
(2) By signing this form, I confirm all information stated is true and correct.

Employee Signature: **Date:**

_____ _____