



# Health Savings Account (HSA) Employer Contribution Authorization

## Employee Information

Employee Name:			
Employee ID Number:		SSN (last 4 digits):	
Address:			
City:	State:	ZIP:	County:
Phone Number:	Email Address:		

## HSA Contribution Authorization

I authorize my employer to contribute funds to my Health Savings Account (HSA) as part of my employment benefits.

Employer Name:		Effective Start Date:	
This authorization request is: <input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Stop Contributions		Deduction Amount: \$	
Frequency: <input type="checkbox"/> Per Pay Period <input type="checkbox"/> Annually <input type="checkbox"/> Semiannually <input type="checkbox"/> Other:			

## HSA Credit Union/Bank Account Information

Name: <b>Civic Federal Credit Union</b>	Routing Number: <b>053185723</b>	Health Savings Account Number:
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## Authorization & Agreement

I hereby authorize \_\_\_\_\_ to contribute and deposit funds to my Health Savings Account (HSA) based on the terms outlined above and acknowledge and agree to the following:

- I certify that the credit union/bank account listed above is my valid HSA account.
- I understand that contributions made by my employer, combined with my own contributions, must not exceed the annual IRS HSA contribution limits.
- I will notify my employer in writing if I wish to change or stop employer contributions, allowing \_\_\_\_\_ business days for processing before the next payroll cycle.
- My employer is not responsible for any fees, penalties, or tax liabilities associated with my HSA.

Employee Signature \_\_\_\_\_

## Employer Use Only

Processed by:	Date Processed:	Payroll Effective Date:
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