Health Savings Accounts

Account Contribution Form

ACCOUNT HOLDER INFORMATION

Name: _____

Account Number: _____

CONTRIBUTION REQUEST

☐ I authorize my employer to deduct the HSA contributions* identified below on a pre-tax basis beginning no earlier than the date my HSA medical plan will become effective. Contributions are subject to federal limits published by the IRS each year. Please fill in desired amount below.

Per pay period: _____

☐ Change my contribution per pay period to: _____

Please indicate start date: _____

☐ Please cancel my deduction for the Health Savings Account from my paycheck.

If you are receiving contributions from your employer, please make sure to calculate those dollars into your monthly contributions to ensure you do not exceed your IRS maximum contribution.

SIGNATURE *(Account holder MUST sign)*

I agree to make this contribution and authorize the per pay period transactions.

_____

Account Holder Signature Date

Please provide to your HR/Payroll Department for processing.

HELPLINE 866.702.9033

EMAIL hsa@choicefinancialgroup.com

Live help available 8:00 am to 6:00 pm CST Monday—Friday

choicefinancialgroup.com/hsa

CHOICE BANK