

Employee Name:		Date:
Address:		SS # :
<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Terminate		
<input type="checkbox"/> Employee <input type="checkbox"/> Family		
Bank Name:	HSA Account Number:	
Payroll Deduction Amount:	\$	

***Important: Please read before signing.***

I understand the eligibility requirements for the type of HSA deposit I am making and I state that I qualify to make the deposit.

I assume responsibility for:

1. Determining that I am eligible for an HSA each time that I make a contribution.
2. Insuring that all contributions I make are within the limits set forth by the tax laws.
3. I am responsible for the tax consequences of any contributions (including rollover contributions) and distributions. I understand the eligibility requirements for the HSA deposits I make and I state that I qualify to make such deposits.

**EMPLOYEE'S SIGNATURE**

\_\_\_\_\_

**PRINTED NAME OF EMPLOYEE**

\_\_\_\_\_

**DATE**

\_\_\_\_\_