



**Employee Direct Deposit Authorization Agreement – Health Savings Account**

USA Payroll Client Number: \_\_\_\_\_ Company Name: \_\_\_\_\_

I hereby authorize my employer, \_\_\_\_\_ (hereinafter COMPANY) to deposit any amount owed me by initiating credit entries to my account at the financial institution (hereinafter BANK) indicated below. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event that COMPANY deposits funds erroneously into my account, I authorize COMPANY to debit my account for an amount not to exceed the original amount of the erroneous credit.

Employee Information:

Employee Name (Please print): \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Type of Request (Please check as applicable and indicate effective date as requested):

\_\_\_\_\_ Begin Deposit effective \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ Change Information effective \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ Cancel Deposit effective \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ Single Plan                      \_\_\_\_\_ Family Plan

Bank Name: \_\_\_\_\_

Health Savings Account Number: \_\_\_\_\_  
(Attach a voided check or deposit slip.)

I wish to deposit: \$ \_\_\_\_\_ .00 per pay period into my Health Savings Account.  
**(Note: 2012: Not to exceed \$3100 annually for single, or \$6250 annually for family.)**

This authorization is to remain in full force and effect until COMPANY and BANK have received written notice from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it.

Employee Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_