Please Send Completed Form To:
Patty San Antonio at Admin. Bldg.
or pat_sanantonio@ewg.k12.ri.us

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: Social Security #:

Employee's HSA Contribution Per Pay Deduction/ Allocation:

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

Additional Debit Card Request: (only complete this section for tax-dependents to be issued debit cards)

Dependent Name: SS#: Date of Birth:

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Dependent Name: SS#: Date of Birth:

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 and I may make changes at any time to my HSA contribution.

(2) By signing this form, I confirm all information stated is true and correct.

Employee Signature: ______________________________ **Date:** ______________________________

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