# HEALTH SAVINGS ACCOUNT
# DIRECT DEPOSIT REQUEST FORM

***(Please keep a copy for your records)***

This form must be completed to have pre-tax deductions deposited into your Health Savings Account (HSA) that you have set up with a financial institution.

## AUTHORIZATION STATEMENT

I authorize Auglaize Co. and the financial institution(s) listed below to initiate debit and credit transactions to my account(s) listed. This authority will remain in effect until I have canceled or changed it in writing.

EMPLOYEE NAME_____ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

COMPANY_____ DATE: _____

EMPLOYEE SIGNATURE_____

☐ New Account ☐ Change Current Distribution ☐ Cancel-Close Account ☐ Waive Participation

## NEW HEALTH SAVINGS ACCOUNT DIRECT DEPOSIT INFORMATION

| BANK NAME | TRANSIT/ABA NUMBER (9 DIGITS) (see example) | ACCOUNT NUMBER (see example) | ACCT - TYPE C = CHECKING | FIXED AMOUNT |
|---|---|---|---|---|
| First Financial | | | | $ |
| | | | | $ |

## CHANGES TO CURRENT HEALTH SAVINGS ACCOUNT DIRECT DEPOSIT

*****ACCOUNT NUMBER IS MANDATORY FOR ALL TRANSACTIONS*****

| (✓) CANCEL ACCT | (✓) CHANGE ACCT | C = CHECKING | ****ACCOUNT NUMBER**** | CURRENT $ = DOLLAR % = PERCENT | NEW $ = DOLLAR % = PERCENT |
|---|---|---|---|---|---|
| ☐ | ☐ | | | | |
| ☐ | ☐ | | | | |

**Benefit's Dept. Approval Signature** _____