Corvallis SCHOOL DISTRICT

2020-21

Health Savings Account Authorization Agreement for Automatic Deposit

Employee Information:

Employee Last Name, First Name, Middle Initial — Social Security Number

Employee Mailing Address (street) (City) (State) (Zip)

Home Phone: _____

How you are enrolled for your Medical Plan: ☐ single or ☐ 2-party + ☐ **medical only** or ☐ **complete package**

Bank Information - HEALTH SAVINGS ACCOUNT

Bank Name ☐ Savings OR ☐ Checking

Banking Routing #: Account #:

I authorize Corvallis School District 509J, hereinafter called Company, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my designated account, indicated above, and the depository named above, hereafter called Depository, to credit and/or debit the same to such account. This authority is to remain in full force and effect until eligibility ends or a new authorization agreement is submitted.

Signature: _____ ***Date:*** _____

Account must be established and form returned to Payroll/Benefit office by open enrollment deadline or as soon as eligible for group insurance.

****COMPLETE THIS PORTION ONLY IF YOU WOULD LIKE TO MAKE AN ADDITIONAL CONTRIBUTION TO YOUR H.S.A. ACCOUNT****

Voluntary Deduction Agreement
Health Savings Account
Corvallis School District 509J

(choose one)
Maximum Contribution Limit: ☐ Employee only or ☐ 2-party + **Monthly Amount:** _____

By signing this form I agree to have the specified employee deductions remain in effect until eligibility or a new authorization agreement is submitted. I also understand I may not change or vary the amount within the Plan Year. I understand that it is my responsibility to ensure that contributions (employer + employee) do not exceed the IRS annual maximum contribution limit for an account owner with $3,550 single and $7,100 family rates for 2020 or $3,600 single and $7,200 family rates for 2021. Individuals age 55 and older may contribute an additional $1,000 per calendar year. I have full responsibility to manage my H.S.A. account in accordance with IRS rules and regulations. I understand the voluntary deduction for my Health Savings Account will be reduced from my compensation on a PRE-TAX basis.

Signature: _____ *Date:* _____

Account must be established and form returned to Payroll/Benefit office by open enrollment deadline or as soon as eligible for group insurance.

Completed by Payroll /Benefit Office: Max contribution: District Contribution: