Corvallis
SCHOOL DISTRICT

2023-24

Health Savings Account Authorization Agreement for Automatic Deposit

Employee Information:

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

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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 (circle one)

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 $3,600 single and $7,200 family rates for 2021 or $3,650 single and $7,300 family rates for 2022. 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: