



EMPLOYEE DIRECT DEPOSIT AUTHORIZATION AGREEMENT
HEALTH SAVINGS ACCOUNT (HSA)

Employee Name _____ Employee ID# _____

I hereby authorize Mount Vernon Nazarene University (MVNU) to initiate credit entries to my account in the financial institution named below, and I authorize the Financial Institution to accept and to credit the amount of such entries to my account.

In the event that a credit entry is erroneously initiated, I hereby authorize MVNU to initiate a correcting debit entry to my account. MVNU will provide to me written notification of such correction and reason therefore. I authorize the Financial Institution to accept and to debit the amount of such entries to my account.

This authority is to remain in full force and effect until MVNU has received written notification from me of its termination in such a time and in such a manner as to afford MVNU a reasonable opportunity to act on it, and in no event shall it be effective with respect to entries processed by MVNU prior to the receipt of notice of termination.

[Empty box for Name of Financial Institution]

Name of Financial Institution

[Empty box for Bank Routing Number (9) Digits]

Bank Routing Number (9) Digits

[Empty box for Account Number]

Account Number

HSA Employee Direct Deposit Effective Date: _____

Employee Deposit Options (select only one):

___ I wish to deposit \$ _____ /Per Pay Check (to start or change)

___ Cancel My Employee Contribution

Maximum Personal Contributions to HSA for 2016

Table with 4 columns: Contribution Type, Annually, Semi-Monthly, Bi-Weekly. Rows include Employee, Employee+1, Family, Family w/2 Employees.

If the Employee is 55+ years of age...

Maximum Personal Contributions to HSA for 2016

Table with 4 columns: Contribution Type, Annually, Semi-Monthly, Bi-Weekly. Rows include Employee, Employee+1, Family, Family w/2 Employees.

Note: If you are maxing out on your annual personal HSA contributions above and participate in the Wellness Program, don't select the HSA fund option as your Wellness Benefit, since that will cause you to exceed your HSA limit.

Employee Signature _____ Date _____

Please attach documentation from your financial institution to verify the Routing and Account numbers.