G&A Partners

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FOR HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTIONS

Instructions: Complete this form and attach a document from your financial institution listing all pertinent information that confirms an HSA bank account is active. Return to the G&A Partners Benefits Department via either email (benefits@gnapartners.com) or fax (1-866-947-2391).

Please print legibly and complete all sections of this form. Failure to do so could cause this form to be returned to you, thus delaying your direct deposit.

ACCOUNTHOLDER INFORMATION:

Employee Name: _____ Social Security Number: _____

Client Name: _____ Client Number: _____

Health Insurance Coverage: ☐ Single ☐ Family

Effective Date of Health Insurance: _____

CHECK ONE OF THE FOLLOWING:

☐ First Time/Initial Setup ☐ Change to Existing Setup ☐ Annual Enrollment ☐ Cancellation

FINANCIAL INSTITUTION INFORMATION:

Bank Name: _____ City: _____ State: _____

Account #: _____ Routing/Transit #: _____

Transaction code used (please verify this with your bank): ☐ Checking ☐ Savings

NOTE: Employee must submit proof from financial institution for the account and routing number. Employees are also responsible for verifying their funds are deposited and available for use prior to writing checks/debiting their accounts.

HSA CONTRIBUTION SOURCE AND AMOUNT INFORMATION:

☐ **Employee Pre-Tax (through Section 125 Plan) Annual Contribution Amount:**

$_____ ☐ Lump Sum/One-Time Contribution ☐ Prorated Per Pay Period

☐ **Employer Annual Contribution Amount:**

$_____ ☐ Lump Sum/One-Time Contribution ☐ Prorated Per Pay Period

NOTE: Deposits may not be available for immediate withdrawal.

By signing below, you are agreeing to the following:

- I hereby authorize my employer to directly deposit my pay and/or employer contributions into the bank account specified.
- This authorization is to remain in force until the company receives written authorization from me of its termination or change.
- I grant my employer the right to correct any electronic funds transfer resulting from an erroneous overpayment by debiting my account to the exact amount of such an overpayment.

_____ _____

Employee Signature (All authorizations must be signed) **Date**

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