

**HEALTH SAVINGS ACCOUNT**

**DIRECT DEPOSIT Employee Authorization**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contribution Amount (per pay period)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Effective Start Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Full Name (Please Print)**

**Bank Name**

**Transit Routing Number**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Account Number**

I hereby authorize Foothills Gateway, Inc. to deposit my Health Savings Account contribution each payday directly into the account named above. This authority will remain in force until I have given written notice that I am terminating it, or until my employer has notified me that this deposit service has been discontinued. I understand that I must give advance notice to allow reasonable time for my instructions to be executed (at least 5 business days prior to payroll). If an incorrect deposit should be made into my account, I authorize my bank and Foothills Gateway, Inc. to make the appropriate adjustments.

--OR--

 I elect ***not*** to contribute to a Health Savings Account until further notice. With this election, I understand I will ***not*** be eligible for any employer matching contribution.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date