



**Health Savings Accounts (HSA)
Direct Deposit Authorization**

Employee Benefits 541-265-4411

Employee Name: _____

Last 5 Digits of SSN: _____

Please obtain this information directly from your bank:

Bank Name: _____

Bank Address: _____

Bank Routing #: _____

Account #: _____

HSA Employee Contribution

District Amount Only

Plan

55 + years

\$ _____

\$ _____

___ Single Plan

YES NO

___ Family Plan

Warning- If you are using US Bank for your HSA, please do not set up an account at your local branch. Benefits will set up the account.

District Allows 3 changes per Calendar year

New plan / Change to plan 1 2 3

Authorization:
I hereby authorize my employer to initiate credit entries and to initiate if necessary debit entries and adjustments not to exceed the amount of any credit posted by LCSD and authorize the depositories named above to credit and or debit the same such account. I understand that my first check may be a physical check due to the bank's prenotification process to verify the information I have provided. **I understand that I must notify LCSD if any of my direct deposit is deposited in a foreign bank or a US financial institution where the entire amount will be forwarded to a bank account in another country.**

Signature _____

Date _____

Cancellation:
I hereby cancel the authority previously given to my employer by this written notification from me of its termination in such time and in such manner as to afford the employer and the depository a reasonable opportunity to act on it. **I also understand that for future Direct Deposit selections, I will not select a foreign bank or a US financial institution where my entire amount will be forwarded to a bank account in another country without notifying LCSD.**

Signature _____

Date _____