Please Send Completed Form To:

ADMINISTRATOR

40 Commercial Way

East Providence, RI 02914

BCBSRIservice@londonhealthusa.com

Health Savings Account
Employee Contribution Authorization Form

Employee Information:

Employer/Company Name:		
First Name:	Last Name:	
Street Address:		
City:	State:	Zip Code:
Date of Birth:	Social Security #:	

Employee's HSA Contribution Per Pay Deduction/ Allocation:

	Annual HSA Amount	***# of Payrolls***	***Per Payroll Amount***
Employee HSA Contribution:	$_______________	divided by ___________	= $ _______________
Employer HSA Contribution:	$_______________	divided by ___________	= $ _______________

Additional Debit Card Request: (only complete this section for tax-dependents to be issued debit cards)

Dependent Name:	SS#:	Date of Birth:
Dependent Name:	SS#:	Date of Birth:
Dependent Name:	SS#:	Date of Birth:
Dependent Name:	SS#:	Date of Birth:

I Understand That:

(1) I agree to have my compensation reduced by the deduction amount(s) stated above. I further understand that the Health Savings Account deduction will be in effect until my participation in the HSA is terminated and I may make changes at any time to my HSA contribution.

(2) By signing this form, I confirm all information stated is true and correct.

Employee Signature: ______________________________ **Date:** ______________________________

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