LOYOLA
UNIVERSITY MARYLAND

HSA Payroll Contribution Form

Last Name, First Name | Employee SSN

Address | City | St | Zip

Email | DOB (MM-DD-YYYY)

❑ New Enrollee
❑ Renewal Enrollment

OFFICE USE ONLY
Effective Date

HSA ACCOUNT – THIS BENEFIT IS SUPPORTED BY BANK OF AMERICA

I request the following amount to be reduced from my paycheck:

Benefit	Yes/No	Paycheck Deduction Amount
HSA	❑ Yes ❑ No	$_____ per paycheck

PREMIUM AGREEMENT FOR HEATH SAVINGS ACCOUNT

Please check one:

☐ I elect to participate in the HSA. *Please read the following and sign below.*

☐ I decline participation in the HSA. *Do not sign below.*

I agree to have my employer deduct pre-tax payroll contributions to fund my Health Savings Account. I understand that if my employment is terminated prior to the end of the Plan Year, contributions will be taken from my final paycheck on a pre-tax basis.

Signature: _____ Date: _____

Sign here *only* if you are participating in the Health Savings Account

AUTHORIZATION

I hereby certify the above information to be correct and true to the best of my knowledge. I understand that the above reductions may correspondingly reduce my future Social Security benefits. My signature on this form certifies that I have received and read the materials explaining the Health Savings Account program.

Signature: _____ Date: _____

OFFICE USE ONLY: