

## HSA Contribution Change Form

Name: \_\_\_\_\_

Current bi-weekly contribution: \_\_\_\_\_

New bi-weekly contribution: \_\_\_\_\_

Effective: (Please Check One)

☐ Next Available Payroll Period

☐ Payroll Period Check Dated \_\_\_\_\_

☐ After Payroll Period Check Dated \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I hereby authorize **MERCER COUNTY** to initiate credit entries to my Health Savings Account at the financial institution named above and to credit the same to such account. If funds to which I am not entitled are deposited to my account, I authorize the financial institution to deduct those funds from my account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. Law. This authorization is to remain in full force and effect until Mercer County has received written notification from me of its termination.