HSA Payroll Deduction Form

☐ **New** ☐ **Change**

Full Name _____

Employee ID # _____

Building/Job Title: _____

Form must be completed and returned to the Benefits Office. (Fax: 913-993-6283)

Pay Cycle: ☐ **Monthly** ☐ **Bi-weekly**

HSA Payroll Amount **$**_____**(per pay period)** ***Effective Date:**_____

***Requests received by the 15th of the month will be processed on the first pay period of the next month.**

Employee Signature_____**Date**_____

For Benefit and Payroll use only:

Benefits Signature_____ **Date**_____

Payroll Signature_____ **Date**_____

Over 55: ☐ **Yes** ☐ **No**

Comments: