CLERMONT COUNTY

HEALTH SAVINGS ACCOUNT DIRECT DEPOSIT AUTHORIZATION

AUTHORIZATION AGREEMENT FOR HEALTH SAVINGS ACCOUNT

This is my authorization for the Clermont County Auditor to automatically credit my semi-monthly employer/employee contributions to my Health Savings Account:

DEPOSIT:

[ ] Checking account

[ ] Savings account _____ (_____) at the
(Account Number) (Bank Transit / ABA No.)

_____ branch of_____in
(Branch) (Financial Institution)

_____, _____.
(City) (State)

I understand that this authorization will be in effect until I notify the Clermont County Auditor in writing that I no longer desire this service, and allow reasonable time to act on my notification. I also understand that if corrections in the credit amount are necessary, it may involve an adjustment (credit or debit) to my account(s).

THIS AUTHORIZATION IS NON-NEGOTIABLE AND NON-TRANSFERABLE

_____ ____XXX-XX_____
(EMPLOYEE NAME) (SOCIAL SECURITY NUMBER)

_____ _____
(DATE) (SIGNATURE)

_____ _____
(EMPLOYEE DEPARTMENT) (PHONE)

PLEASE ATTACH VOIDED CHECK OR BANK ISSUED AUTHORIZATION FORM
PLEASE RETURN THE FORM TO AUDITOR/PAYROLL