HEALTH SAVINGS ACCOUNT FORM

Completion of this form authorizes the State of South Dakota to make a contribution into your Health Savings Account (HSA). Your deposit will be sent directly to the HSA financial institution with proof of deposit appearing on your bank statement. Enrollment in the $2,000 Deductible Health Plan and an HSA are required to receive the contribution.

AUTHORIZATION FOR DEPOSIT

I authorize the financial institution named below to accept a contribution from the State of South Dakota for my HSA.

I have attached a voided check or deposit slip from the financial institution to which the deposit will be made.

Financial Institution Information:

(Name of Financial Institution – Please Print)

(Street / PO Box)

(City) (State) (Zip Code + 4)

Required HSA Information:

Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account Number:_____

Employee Information:

(Employee Name – Please Print) (Daytime Phone #)

(Street / PO Box)

(City) (State) (Zip Code + 4)

(Employee Alternate ID or SSN)

(Employee Signature) **(Date)**

* COBRA & Retiree health plan members are not eligible for the $300 contribution. Revised 05/09

Mail to: PMB 0141-1
BOP – Benefits Program
500 E Capitol Ave.
Pierre, SD 57501
Fax: 605.773.6840