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## HEALTH SAVING ACCOUNT (HSA) AUTHORIZATION AGREEMENT

NEW     
  CHANGE     
  CANCELLATION

AUTHORIZATION INFORMATION	
Employee Printed Name:	_____
Telephone Number:	(     ) _____
Social Security Number:	_____ - _____
Deduction Amount:	\$ _____ .00 per month <small>(Whole dollars only. Not to exceed 1/12<sup>th</sup> of total deductible amount, unless over the age of 55.)</small>
Effective Date:	_____ / _____ / _____

I hereby authorize Southern Medical Corporation, hereinafter called **COMPANY**, to initiate and / or change payroll deductions from my paycheck for the requested contribution to my Health Savings Account, hereinafter called **HSA**. Additionally, I authorize the **COMPANY** to apply these deductions as credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my **HSA**.

I understand this request will stay in effect and may not be changed for a minimum term of one quarter of the calendar year. The only exception to this will be if my benefit coverage is changed or terminated due to a qualifying event.

This authorization is to remain in full force and effect until **COMPANY** has received written notification from me of its termination in such time and in such manner as to afford **COMPANY** and my **HSA** institution a reasonable opportunity to act on it.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_