

CELINA CITY SCHOOLS

2024 HSA DIRECT DEPOSIT

Account Holder Name: _____

Financial Institution Name _____

Financial Institution Routing Number _____

Account Number _____

Type of Account HSA (Health Savings Account)

Amount per pay you would like deposited in your account
(this amount is in addition to the Board's contribution) \$ _____

Payroll Date You Would Like Contribution to Start _____

Signature _____ Date _____

PLEASE ATTACH A VOIDED CHECK OR DEPOSIT TICKET TO THIS FORM