



**Health Savings Account
Employer Contribution Form**

This form is to be used for Employer Contributions

Instructions: By completing this form you certify that this is an eligible HSA contribution and the information you provide is accurate. If the tax year information is left blank the contribution will be applied to the current year. Fax completed form to Bank Office Support at 603-527-5034. Please use additional forms if necessary.

	Employee Name and SSN	Account Number	Amount	Tax Year
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

Please make the above contributions to the designated employee HSA accounts effective _____ .
(date)

Please use the attached check, debit the following account _____ for these contributions.

Authorized by: _____ on _____

Authorized Signature: _____

Received By: _____	Completed By: _____	Date _____
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