Blue Cross Blue Shield of Rhode Island

Please Send Completed Form To:
ADMINISTRATOR
40 Commercial Way
East Providence, RI 02914

BCBSRIservice@londonhealthusa.com

* HSA+ are deducted over 26 paychecks which include summer
* For individual, additional HSA+ funds have a maximum of $2,000.
* For family, additional HSA+ funds have a maximum of $4,000.

Health Savings Account
Employee Contribution Authorization Form

Employee Information:

Employer/Company Name:		
First Name:	Last Name:	
Street Address:		
City:	State:	Zip Code:
Date of Birth:	Social Security #:	

Employee's HSA Contribution Per Pay Deduction/ Allocation:

	Annual HSA Amount	*# of Payrolls*	*Per Payroll Amount*
Employee HSA+ Contribution:	$_____	divided by 26	= $_____
Employer HSA Contribution:	$_____	divided by _____	= $_____

Additional Debit Card Request: (only complete this section for tax-dependents to be issued debit cards)

Dependent Name:	SS#:	Date of Birth:
Dependent Name:	SS#:	Date of Birth:
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I Understand That:

(1) I agree to have my compensation reduced by the deduction amount(s) stated above. I further understand that the Health Savings Account deduction will be in effect until my participation in the HSA is terminated and I may make changes at any time to my HSA contribution.

(2) By signing this form, I confirm all information stated is true and correct.

Employee Signature: _____ **Date:** _____

* Please return form to Louise Desmarais in The Business Office.