

**Health Savings Account
Payroll Deduction**

Employee Name: _____

Work Location: _____

Effective Date of Election: _____

BYN/Mellon HSA Account Number _____

I elect to have the following amount deducted per pay period: \$ _____

I wish to change the amount of my payroll deduction per pay period to: \$ _____

I elect to stop my deduction _____

I understand my deductions will be taken out on a pre-tax basis

EMPLOYEE SIGNATURE

DATE

SUPERVISOR SIGNATURE

DATE