

Miami Trace Local School District
3818 State Route 41 NW
Washington C.H., OH 43160

Health Savings Account Agreement Form

Authorization Agreement

I hereby authorize **Miami Trace Local School District** to initiate automatic deposits to my account at the financial institution named below. I also authorize **Miami Trace Local School District** to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **Miami Trace Local School District** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Miami Trace Local School District** receives a written notice of cancellation from me or my financial institution, or until I submit a new health savings account form to the Payroll Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____

Checking
☐

Savings
☐

Amount: _____

Signature

Authorized Signature (Primary): _____ Date: _____

Please attach a voided check or deposit slip and return this form to the Payroll Department.