EMPLOYEE HSA DIRECT DEPOSIT AUTHORIZATION AGREEMENT

(Please Complete One Form for Each Deposit Request)

2020

Company #: _____Company Name: Marlboro College

I (we) hereby authorize and request the COMPANY, to make payment of any amounts owing to me (either of us) by initiating credit entries to my (our) account indicated below in the bank named below, hereinafter called BANK, and I (we) authorize and request BANK to accept any credit entries initiated by COMPANY to such account and to credit the same to such account without responsibility for the correctness thereof.

I (we) authorize and request COMPANY to effect repayment to COMPANY for amount s owed it because of a prior erroneous credit initiated to my (our) account if prior to the correcting entry, the COMPANY has sent or delivered to me written notice of the correction and the reason therefore; and the correcting entry is transmitted in such time as to be delivered or made available to BANK before midnight of the tenth day next following settlement for the erroneous entry.

It is understood that this agreement may be terminated by me (either of us) at any time by written notification to COMPANY or BANK. Any such notification to COMPANY shall be effective only with respect to entries initiated by COMPANY after receipt of such notification and a reasonable opportunity to act on it. Any such notification to BANK shall be effective only with respect to entries credited to my (our) account by BANK after receipt of such notification and a reasonable time to act on it.

I (we) recognize, acknowledge and accept this service is being provided for my (our) convenience. As such, I (we) agree to hold the COMPANY, PayData Payroll Services, Inc., each participating bank and NACHA harmless from any claim incident to the operation of this plan, arising from any act or omission by the COMPANY and/or PayData Payroll Services, Inc. and their employees, including without limitation any claim based on alleged loss as a result of non-credit of any deposit, and any claim which may be made by any depositor as a result of the rejection of any of his/her debits because of insufficient funds arising from the failure to credit deposits to his/her account.

Employee #: _____ Name of Institution: _____

Routing #: _____ Account #: _____

Account Type:

__X__ Checking (HSA)

Deposit Options: (Select Only One)

_____ Cancel H.S.A. Direct Deposit

_____ Deposit $_____ of Gross Pay per Period
(Employees on Medicare are not eligible for H.S.A accounts)

Suggested deposit to equal total deductible
Single plan**: $76.92** bi-weekly or $2,000 annual total
Multi-member plans: **$153.85** bi-weekly or $4,000 annual total

Maximum allowed by law
Single plan: **$136.54** bi-weekly or $3,550 annual total
Multi-member plans: **$273.08** bi-weekly or $7,100 annual total

Catch-up allowed for individuals aged 55 or older
Single plan: **$38.46** bi-weekly or $1,000 annual total
Multi-member plans: **$38.46** bi-weekly or $1,000 annual total

Employee Name: _____
(Please Print)

Employee Signature: _____ Date: _____

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