CLEAR FORM

Health Savings Account (HSA)	Financial Institution Name Branch Name or Number Institution ID # / Participant ID #

HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTIONS

PARTICIPANT INFORMATION

Name

Address

City State Zip

Social Security Number

Account Number(s)

CONTRIBUTION TYPE

The contribution is being made by:

❑ HSA Owner

❑ Employer

❑ Other _____ *(name of entity, relative, etc.)*

CONTRIBUTION AMOUNT

Total annual contribution cannot exceed the statutory maximum. The HSA owner should seek advice from his/her tax advisor or accountant for assistance in determining the amount he/she can contribute.

$_____ HSA Owner contribution

$_____ Employer contribution

$_____ Contributions by others *(entity or individual)*

EFFECTIVE YEAR

❑ Prior Tax Year

❑ Current Tax Year

A contribution can be made up to April 15th to be considered a contribution for the prior tax year.

SIGNATURE

HSA Owner ✕ Date

BANK USE ONLY

Financial Institution Representative Signature ✕ Date

Printed Name of Financial Institution Representative

Date Contribution Received Date

DO NOT RETURN THIS FORM TO LT TRUST COMPANY. This form is intended for internal recordkeeping only.