AVIDIA HEALTH

# HSA - Employer Contribution Form

Instructions: Complete form; either type or print clearly. Full SSN or Account # is required. Contribution Year must be provided. Send list and check (payable to Avidia Bank) for the grand total to: Avidia Bank, P.O. Box 370, Hudson, MA 01749.

**Initial Contributions - Please be sure accounts have been opened prior to sending initial contributions.**

## Employer Check & List HSA Contribution Form:

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|---|---|---|---|---|---|
| Company Name: | | | | | |
| Company Address: (Street, City, State, Zip) | | | | | |
| Contact Name: | | Email: | | | |
| Phone Number: | | Ext: | | Would you like an email confirmation of this deposit? | ☐ Yes ☐ No |
| Check Amount: | | Check #: | | **Contribution Year (Required):** If not specified, you contribution will be deposited for the year in which it was received. Be sure to update your form every year. Enter Year (yyyy):_____ | |

| **Employee Name:** | | **You must provide the either full SSN or Acct. #** | | **Contribution Amount:** | | |
|---|---|---|---|---|---|---|
| **First Name:** | **Last Name:** | **Social Security #:** | **Account #:** | **Employee:** | **Employer:** | **Total:** |
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FDIC

The balance in your HSA is insured by the Federal Deposit Insurance Corporation (FDIC), and subject to applicable deposit limits.

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