

HEALTH SAVING ACCOUNT

DIRECT DEPOSIT AUTHORIZATION FORM

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYROLL DEPOSITS. (Please attach a check marked "VOID" or a savings account deposit slip.)

I hereby authorize American Printing House for the Blind to deduction the amount listed below from my check pre-taxed and deposit it into the bank account listed below. I also authorize APH to initiate, if necessary, debit entries and adjustments for any credit entries in error in my account indicated below.

H.S.A. Deduction amount _____

Bank Name _____

City _____ State _____

Transit/ ABA No. _____

Account No. _____

Account Type _____

Signed _____

Printed Name _____

Date _____