Aetna HealthFund® Health Savings Account (HSA) Electronic Funds Transfer Authorization (EFT)

Instructions

- This form allows you to transfer funds into your HSA directly from your checking account. You may use this form to authorize either a one-time transaction or a periodic transfer. All transfers from your checking account will be in addition to amounts you contribute through your benefits plan, payroll deduction or other means.
- Please keep this form for your files.
- To authorize an automatic transfer, send this completed form to: **HSA Operations**
  P.O. Box 30207
  Tampa, FL 33630-3207

Account Holder Information

Name : Last	First		MI
Birthdate (MM/DD/YYYY) / /	Social Security Number / /	Daytime Telephone Number ( ) -	Evening Telephone Number ( ) -

Street Address

_____

_____

_____

City State Zip Code Country

EFT Deduction Amount

Please check the following that applies:

☐ I authorize Aetna to deduct a one-time electronic funds transfer (EFT) withdrawal from my designated bank account indicated on the attached check in the amount of $ _____.

☐ I authorize Aetna to deduct a monthly electronic funds transfer (EFT) withdrawal from my designated bank account indicated on the attached check in the amount of $ _____.

Authorization

By signing below and including a blank and voided check, I hereby authorize Aetna Life Insurance Company or its designee ("Aetna") to initiate debit entries to the account indicated on the attached check. I acknowledge that it is my responsibility to ensure there are sufficient funds available in the indicated account at the time of withdrawal. I understand that there is a fee associated with the one-time electronic funds transfer withdrawal. If this authorization is provided in connection with a new HSA, I understand that the initial deposit will be processed within 7-10 days after the HSA has been opened and my identification has been verified, and recurring monthly debits will start approximately 30 days from that date. Aetna may, for business reasons, modify the date of the EFT monthly withdrawal by increasing the number of days between monthly withdrawals. This authority will remain in full force and effect until Aetna has received written notification from me of its termination in such time and in such manner as to afford a reasonable opportunity to act on it.

X _____ _____ _____

Signature Print Name Date Signed

PLEASE ATTACH VOIDED CHECK HERE (Note: If the voided check is from a business account, please provide a copy of the Business Certificate, Partnership Agreement, or Corporate Resolution.)

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