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 981012, Boston, MA 02298-1012.

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

Employer Check & List HSA Contribution Form:

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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				Grand Total:		$

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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