HEALTH SAVINGS ACCOUNT

(DIRECT DEPOSIT INFORMATION)

St. Croix Falls School District

Employee Authorization

I authorize the St. Croix Falls School District and the financial institutions listed below to initiate electronic credit entries and, if necessary, debit entries and adjustments for any credit entries in error to my accounts as listed below each pay period. This authority will remain in effect until I have cancelled it in writing.

Financial Institution	Routing Number	Account Number	Type (C/S)	Amount or Net

Employee Name: ____

Social Security Number: __________________________

Signature: ____

Date: __________________________

**Please return completed form to the Business Office.

The mission of the School District of St. Croix Falls is to provide a supportive, student-centered learning environment that cultivates character, fosters academic excellence, and embraces diversity.