

DEPOSIT TO MEDICAL SAVINGS ACCOUNT

| HEALTHCARE FUND WWW.ropssd.org | | | | Date: | | |
|----------------------------------|-----------------------|-------------------|------------------------|--------------|---------------------------|--|
| | Account Holder's Name | | Social Security Number | Am | ount (Minimum of \$10.00) | |
| 1. | | | | \$ | | |
| 2. | | | | \$ | | |
| 3. | | | | \$ | | |
| | | | Total: | | | |
| oayer's Name (Print): | | SSN: | | | • | |
| fel No | Signature of Payer: | | | | | |
| DEPOSITS MAY NOT BE AVAILABLE FO | OR IMMEDIATE USE | | | | ROPSSA 900 - 20 (1 | |
| | | FOR OFFICE USE ON | ILY | | | |
| DATE PAID: | AMOUNT PAID: | RECEIPT NO.: | RECEIVED BY: | RECEIVED BY: | | |
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