



## Health Savings Account (HSA) Employee Enrollment Form

Employee Information		
Last name	First name	M.I.
Date of birth	Social security #	Employer
Mailing address	City	State/Zip
Street address (required)	Home phone # (area code)	Work phone # (area code & ext.)
Coverage for Employee only <input type="checkbox"/> Employee and family <input type="checkbox"/>  Plan elected \$1,500 deductible <input type="checkbox"/> \$2,500 deductible <input type="checkbox"/>	Maximum contribution (total of employee & employer contributions): \$3,050.00 Employee only \$6,150.00 Employee and 1 or more dependents  Catch-up contribution <input type="checkbox"/> An additional \$1,000 catch-up contribution is allowed for participants who are 55 and older	
Do you currently have an HSA account: <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had an account in previous years: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Note: Effective January 1, 2011, over-the-counter medications will require a prescription from your provider for the item to be considered a qualified medical expense. Please call (800) 718-8328 if you have any questions.**

Account Setup	
<b>Employee contribution deducted per month:</b>  \$ _____ (fixed amount pulled per pay period):	<b>Total annual employee contribution:</b>  \$ _____
<b>Employer contribution per month:</b>  \$ _____ (fixed amount contributed per month):	<b>Total annual employer contribution:</b>  \$ _____
<b>Number of pays contributions are pulled from yearly:</b>  <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 24 <input type="checkbox"/> 26 # _____ (remaining pay periods for participants enrolling mid-year)  (This information will be used by your employer to setup a scheduled pre-tax payroll deduction. If enrolling mid-year, calculate total annual contribution by multiplying the salary reduction per pay period by the remaining pay periods left in the fiscal year.)	<b>Total annual contribution:</b>  \$ _____  APEHP will cover the administration fee for you if you remain on an APEHP high deductible health plan.

Primary Beneficiary Information		
Name	Relationship	Social security #
Address	City	State/Zip

### Authorization and Certification

- I understand that I must be covered by a qualified high deductible health plan, not covered by another health plan including Medicare, and cannot be claimed as a dependent on another individual's tax return.
- In compliance with the USA PATRIOT Act, HealthEquity must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, you may be asked to provide additional information and/or documentation before your account can be established.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you have any questions about your HSA, please call HealthEquity at (866) 346-5800.