



Health Savings Account Employer Enrollment Form

Employer Information

Company Name: _____ Tax ID Number: _____
 Contact Name: _____ Title: _____
 Phone Number: (_____) _____ Fax Number: (_____) _____
 Email Address: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Billing Address (if different): _____
 City: _____ State: _____ Zip: _____
 Industry Code (SIC): _____ Total Medical Benefit Eligible Employees: _____ Total Employees: _____

Insurance Information

Insurance Company Name: _____ Group Effective Date: _____
 Group Number: _____ Plan Renewal Date: _____
Single Annual Deductible \$ _____ **Family** Annual Deductible: \$ _____
 Broker ID: _____ Broker Name: _____
 Broker Phone: _____ Agency Name: _____

Health Savings Account Information

An employer may make contributions to its employees' HealthEquity HSAs. The employer may also collect employee contributions to their HSAs via Payroll Deduction and remit those contributions to HealthEquity once the HSAs have been established.

The employer contribution must be comparable for each employee within the same coverage type (individual or family).

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, your employees may be asked to provide additional information and/or documentation before their accounts can be established.

Signature

 Print Name Signature Date

The balance in your HSA is insured by the Federal Deposit Insurance Corporation (FDIC), subject to applicable deposit limits.



Please Mail or Fax Completed Forms to:
HealthEquity Enrollment
 15 West Scenic Pointe Drive, Suite 400
 Draper, UT 84020
 Fax: 520-844-7090

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