

## Health Savings Account **Employer Enrollment Form**

Employer Information		
Company Name:	Tax ID Number:	
	Title:	
Phone Number: ()	Fax Number: ()	
Email Address:		
Street Address:		
City:	State:	Zip:
Billing Address (if different):		
City:	State:	Zip:
Industry Code (SIC): Total Me	edical Benefit Eligible Employees:	Total Employees:
Insurance Information		
Insurance Company Name:	Group Effective Date:	
Group Number:		
Single Annual Deductible \$	_	al Deductible: \$
roker 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