HealthEquity

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.

FDIC

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