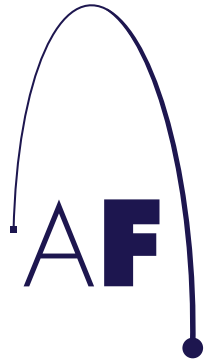


\*Available with Option C: High Deductible Health Plan only.

**AMERIFLEX**<sup>®</sup>

HEALTHCARE SAVINGS ACCOUNT  
ENROLLMENT REQUEST FORM



**Instructions:**

1. To avoid processing delays, please complete all fields on the application
2. Send completed form to the Benefits Office via mail, fax, or email (contact information below)
3. Please do not submit check contributions with this form

**Company Name:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_ Telephone (Required): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employee Address (Street address required; no PO Box): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employee DOB (Required): \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee E-mail Address (Required): \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<u>Employee's Healthcare Savings Account Contribution</u>			
\$ _____ Annual Contribution	\$ _____ Per Pay	_____ Date of First Payroll	_____ # of Remaining Pays

**You will receive an AmeriFlex Convenience Card<sup>®</sup> debit card and initial checkbook to access your HSA funds. If you wish to request an additional card for use by an authorized user - either your spouse or a qualified dependent - please complete the section below.**

Spouse Name: \_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address to issue card (if different than participant): \_\_\_\_\_

**All dependents must be over the age of 18 to receive the AmeriFlex Convenience Card<sup>®</sup>.**

Dependent Name: \_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address to issue card (if different than participant): \_\_\_\_\_

I understand :

(1) That the purpose of this HSA Contribution Form is to document my HSA contribution that will be made via payroll deduction if applicable. I also understand that this will serve as my HSA Enrollment Form in order to open an HSA account, and agree to return the bank's signature card.

(2) The eligibility requirements for deposits made to my Health Savings Account (HSA) and state that I qualify to make deposits to this account. I assume complete responsibility for:

- a. Determining my eligibility for an HSA each year I make a contribution.
- b. Ensuring all contributions made to my account are within the limits set forth by the tax laws.
- c. Any tax consequences of contributions (including rollover contributions) and distributions.

\_\_\_\_\_  
Employee Signature Date