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

AMERIFLEX®

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: _____/_____/_____

Employee's Healthcare Savings Account Contribution

$ _____ Annual Contribution $_____ Per Pay _____ Date of First Payroll _____# of Remaining Pays

You will receive an AmeriFlex Convenience Card® debit card and initial checkbook to access your HSA funds. If you wish to request an addtional 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®.

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

Mail: BAYADA Home Health Care | Benefits Office | 101 Executive Drive | Moorestown, NJ 08057 | Fax: 800-355-0954
Email: benefits@bayada.com