

HEALTHY DOLLARS

HSA BENEFIT ENROLLMENT

Company Name: _____

Employee: _____ SS#: _____ Date of Birth: _____

Effective Date: _____ Phone Number: _____

Address: _____

Email Address: _____

Medicare Beneficiary No Yes, If Yes, Medicare ID: _____

Dependent Info – Please list all eligible dependents & spouse.

| Name: (Last, First MI) | Date of Birth | Social Security Number | Medicare ID |
|------------------------|---------------|------------------------|-------------|
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I hereby elect to enroll in the HSA plan agreeing to be bound by all terms, condition and limitations of the Plan. I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I assume complete responsibility for determining my eligibility for an HSA each year I make a contribution, ensuring all contributions made to my account are within the limits set forth by the tax laws and any tax consequences of contributions (including rollover contribution) and distributions.

Signature of Employee: _____

Date: _____