Enrollment/Change Form

HEALTH SAVINGS ACCOUNT (HSA)

Employer

Effective Date of Enrollment *(MM/DD/YYYY)*

Employee Name - *First Name, Middle Initial, Last Name*

Hire Date *(MM/DD/YYYY)*

Member ID *(set by employer. Typically an employee ID or SSN.)*

Birth Date *(MM/DD/YYYY)*

Street

Email Address

City State ZIP

Phone Number

Employment Status:

☐ Full Time ☐ Part Time

Social Security Number (SSN)

I authorize my employer to initiate the following payroll deduction to contribute to my HSA:

Per Pay Deduction

$

Plan Year Election

$

IRS LIMITS AVAILABLE AT:
BenefitResource.com/plan-limits

This is a: ☐ New enrollment ☐ Change in previous enrollment

The combination of employee, employer and any third-party contributions may not exceed the stated limits.

PLEASE CERTIFY THE FOLLOWING:

- I understand the eligibility requirements for contributions made to my Health Savings Account and state that I qualify to make contributions to this account.
- I assume complete responsibility for: (1) Determining my eligibility for an HSA each year a contribution is made, (2) ensuring all contributions made to my account are within the limits set forth by the tax laws and (3) that any tax consequences of contributions (including rollover contributions) and distributions.
- I authorize Benefit Resource, my employer and/or their third party service providers to exchange information about my identity, enrollment elections, status and other information necessary to facilitate direct deposits to my HSA and to accomplish other purposes related to the payment of healthcare expenses. I agree to indemnify and hold harmless my employer, the Bank, my insurance provider, and their third party service providers against claims or losses that any of them may suffer in reliance on this authorization, and release each of them from any claims or liability based on this authorization.

Signature

Date *(MM/DD/YYYY)*

RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

EMPLOYERS ONLY - This section must be complete for employee to be entered into new enrollment

Deduction Cycle: ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly

☐ Other:

Pay date of first HSA deduction(s):

HSA Pay Dates This Year:

EMPLOYERS: Retain this document for your records. Do NOT send it to BRI. The required information should be sent to Benefit Resource via your normal file exchange process.