HSA Enrollment Request Form

Ameriflex

INSTRUCTIONS:

1. To be submitted by employer.
2. To avoid processing delays, please complete all fields on the application.
3. Send completed form to Ameriflex via mail, fax, or email (contact information below).
4. 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: _____

Member ID (which may be your SSN): _____

Employee DOB *(required)*: _____

Employee Email Address *(required)*: _____ Effective Date: _____

EMPLOYEE'S HEALTH SAVINGS ACCOUNT CONTRIBUTION

Annual Contribution: $_____ Per Pay: $ _____

Date of First Payroll: _____ Number of Remaining Pays: _____

You will receive an Ameriflex Convenience Card® debit card 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: _____ SSN: _____ 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: _____ SSN: _____ 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.

(3) The Health Savings Account I'm choosing to open is subject to all applicable rules and regulations adopted by the designated bank. My signature acknowledges my acceptance of the Truth in Savings Disclosure governing these accounts. The designated bank may order a consumer report from a credit reporting agency in order to evaluate whether I am applicable for this account. The Truth in Savings Disclosure is available at http://www.fdic.gov/regulations/laws/rules/6500-3400.html.

Employee Signature **Date**

Please fax or email to your dedicated Ameriflex Account Executive:

Fax: 800.282.9818 **Email:** forms@myameriflex.com