Health Savings Account (HSA) – Enrollment Form

** Starred items below are required*

Employee Name*: _____ Social Security Number*: _____

Street Address*:_____

City*: _____ State*: _____ Zip*:_____

Mailing Address *(if different)*: _____ Date of Birth*: _____

Telephone Number*: _____ Email Address: _____

Effective Date*: _____ Payroll Schedule*: _____

Employer Name*: _____

HSA Election Amount, Trustee, and Insurance Carrier Information

I elect $_____ X _____ = $ _____ for HSA contributions for the plan year.
(per payroll deduction) (# of payroll deductions) (election amount)

I will utilize the following Trustee to establish my HSA:

☐ UMB

Name of Insurance Carrier: _____ Coverage: ☐ Single ☐ Family

Please Read the Terms and Sign Below

I certify that I have examined the information provided on this form and understand and agree the HSA that I have applied for will be governed by the terms and conditions, including the fees, disclosed in the documents that will be mailed to me within ten (10) days by the HSA Trustee after my HSA has been opened. I agree to comply with these terms and applicable code sections. I understand that in order to establish the HSA I either have self-only or family coverage under the Employer Group Health Plan which I understand qualifies as a high deductible health plan (HDHP) under Code §223(c)(2). I also certify that I cannot be claimed as a tax dependent by someone else and that I am not receiving Medicare benefits. I further certify that I am not covered by any other non-HDHP health plan, general purpose health flexible spending account (health FSA) or general-purpose health reimbursement arrangement (HRA). I elect the amounts shown above and understand that any amounts contributed by me and/or my Employer to my HSA are subject to certain aggregate limits under Federal tax law. By providing my electronic mail address, consent is given to receive items regarding the HSA, enrollment, claims, disbursements (including personal health information in electronic form), as well as related plan information and important announcements. I understand that the information sent by DBS to the electronic mail address provided will be available to me as well as anyone else that I may allow access to such electronic mail address. I agree that Trustee's use of my information will be governed by Trustee's privacy policy which will be delivered to me with the terms and conditions of the HSA I request that an HSA debit card will be mailed to me so that I can use it to access funds in my HSA, and I acknowledge that my use of the debit card will be governed by the Cardholder Agreement that will be sent with the Card. I hereby authorize Diversified Benefit Services, Inc. (DBS) to initiate credit and/or debit entries to my HSA at the financial institution that handles my HSA. Additionally, I hereby authorize the financial institution to accept and to credit or debit any entries indicated by DBS to my HSA. I acknowledge and agree that in the event that DBS credits funds incorrectly to my HSA and/or in the case of an overpayment (fraudulent, inadvertent or otherwise); I authorize DBS or my Employer to debit my account for an amount not to exceed the amount of the incorrect credit. I agree to hold DBS harmless from loss and to indemnify DBS limited to the amount of the transaction. Any dispute arising out of or in connection with this agreement, if not resolved through other methods, shall be determined in accordance with the law governing the HSA. I also hereby authorize the Trustee, the insurer of my high deductible health plan, my employer and/or their third party service providers to exchange information about my identity, enrollment elections and status and other information necessary to establish my HSA at the Trustee, 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 Trustee, 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. These authorizations are to remain in full force and effect until my employer and financial institution have received written notice from me of its termination. The written notice shall be delivered in such a manner as to afford my Employer and financial institution a reasonable time to effect the change. I also understand that DBS is not engaged in giving tax or legal advice and that I have consulted with my tax accountant on the appropriateness of the HSA for me. I also understand that my monthly Social Security retirement benefit, if I receive one, may be reduced slightly by contributing pre-tax dollars to the HSA.

Employee Signature: _____ Date: _____

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