

Instructions

1. Complete this form in order to open an HSA. (* = Required Fields)
2. Fax the completed form to (770) 670-6964 or forward it to: Admin America (TPA), P.O. Box 1209, Alpharetta, GA 30009-1209
3. If you have any questions regarding this form, please call (770) 992-5959 or (800) 366-2961

Accountholder Profile Information

<input type="text"/> *Name (Last, First, MI) <input type="text"/> - <input type="text"/> - <input type="text"/> *Social Security Number <input type="text"/> *Employee ID <input type="text"/> *E-mail Address <input type="text"/> *Address Line 1 (cannot be PO Box) <input type="text"/> *Address Line 2 (cannot be PO Box) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> *City *State *Zip <input type="text"/> - <input type="text"/> - <input type="text"/> *Home Phone	<input type="text"/> - <input type="text"/> - <input type="text"/> *Daytime Phone Number <input type="text"/> *Date of Birth <input type="checkbox"/> Male <input type="checkbox"/> Female *Gender <input type="checkbox"/> Married <input type="checkbox"/> Single *Marital Status <input type="text"/> *Mother's Maiden Name <input type="text"/> *Hire Date <input type="text"/> *Hours Worked Per Week <input type="text"/> *Payroll Frequency <input type="text"/>
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Election

Please choose one of the following enrollment options.

I am enrolling in an HSA through my employer. I authorize my employer to deduct my HSA contributions from my pay and forward them to my HSA. (Please complete the section immediately below)

Note: Your employer may also make a contribution to your HSA that will apply to your maximum contribution allowed. You are solely responsible for determining whether contributions to an HSA exceed the maximum annual contribution limitation. You are also responsible for notifying the custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution.

*Indicate an annual employee election \$ Employee Annual Contribution **or** \$ Per Pay Period Contribution **or** a pay period election:

*Indicate HDHP Coverage Level: Self-only or Family/Other

*Indicate if you are enrolled in an HDHP through your employer: Yes or No

Your contributions will be withdrawn from your pay in each pay period. If your employer maintains a cafeteria plan that permits HSA contributions, your contributions will be made with pre-tax dollars. You may also make contributions outside of your employment. If you would like to make a contribution immediately, please complete an HSA Contribution Form and submit that form with your payment.

Debit Card

Would you like to access your HSA funds using a debit card? Yes No

Note: To issue separate debit cards to any dependents 18 years of age or older, please complete and submit the Additional Debit Card Request Form.

Reimbursement Method

Please select your primary method of reimbursement from your HSA.

- Direct Deposit – You will need to provide your bank account information in the Direct Deposit Setup Section.
- or
- Check – All reimbursements paid by sending you check. If choosing this option, skip the Direct Deposit Setup Section.

Direct Deposit Setup

This section is required if you have chosen Direct Deposit as your HSA Reimbursement Method above.

*Bank Name

*Address

Checking Savings

*Account Type

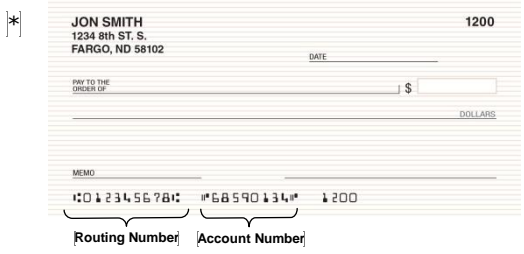
*City

*Routing Number

*State

*Zip

*Account Number



Beneficiary Designation and Information

I designate the following individual(s) or entity as my primary or contingent death beneficiary(ies) of this HSA. If I am married in common law or in a community or marital property state, I must designate my spouse as my Primary Beneficiary unless spouse's signature is obtained and notarized below. Share percentages must equal 100% for primary and 100% for contingent.

No.	Name and Address	Date of Birth	Social Security Number	Primary or Contingent	Relationship	Share %
1.	_____	_____	_____	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	_____
2.	_____	_____	_____	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	_____
3.	_____	_____	_____	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	_____

Please check one of the following:

- I am not married. If I become married at a future date, I must complete a new Beneficiary Designation form.
- I am married. I understand that if I choose to designate a primary death beneficiary other than my spouse, he or she must agree to the designation by signing below. My spouse's signature must be notarized.

Signature of Spouse

Subscribed and sworn to before me this _____ day of _____, 20____
