P.O. Box 30192 Salt Lake City, UT 84130-0192 801-442-5038/800-538-5038 **selecthealth.org**

Health Savings Account Enrollment and Authorization to Disclose Health Information to HealthEquity® Form

Complete this form if you have chosen a High Deductible Health Plan (HDHP) plan with HealthEquity as your HSA administrator. (See your application/enrollment form.)

If you have chosen an HDHP plan and you fail to complete this form, an HSA will not be set up for you. However, failure to complete this form will not affect your health insurance coverage under your HDHP plan.

Policyholder's Last Name ____________________ First Name ____________________ Middle Initial ________

Social Security# ______________________________ Birth Date ______ /______ /______

A. HSA ENROLLMENT

This Enrollment Form will open an HSA that is used to accumulate assets for the payment of qualified healthcare expenses. Your HSA is your financial asset even if you change health plans. To open an HSA, you must meet three criteria:

1. You must be covered by a qualified HDHP (your HipUtah plan is a qualified HDHP);
2. You generally cannot be covered by another health plan, including Medicare; and
3. You cannot be claimed as a dependent on another individual's tax return.

These criteria are explained in more detail in the HSA Custodial Agreement available at www.healthequity.com.

I understand the following about HSA enrollment:

1. By signing this form, I have requested an HSA to be set up in my name with HealthEquity;
2. I have read, understand, and accept my obligations under the HSA Custodial Agreement; and
3. I certify that I am eligible to open and contribute to an HSA.

B. AUTHORIZATION

I authorize SelectHealth to disclose medical claims information about me to HealthEquity, as the administrator of my HSA, for purposes of administering and coordinating reimbursements under my account.

C. IMPORTANT PRIVACY INFORMATION

I understand the following information:

1. SelectHealth, HIPUtah's administrator will not condition payment, enrollment, or eligibility for health plan benefits on my signing this Authorization;
2. This Authorization will apply to all claims incurred while this Authorization is in effect;
3. I may refuse to sign this Authorization, or I may revoke it at any time for any reason, except to the extent that: a) SelectHealth has already made disclosures in reliance on this Authorization; or b) claims have already been incurred before the revocation. However, if I do so, it will limit HealthEquity's ability to provide me account administration services;
4. I may revoke this Authorization by sending a written request to SelectHealth;
5. Once SelectHealth discloses information according to this Authorization, SelectHealth cannot guarantee that this information will not be redisclosed to a third party or that this information will be protected by federal and state law governing the use and disclosure of identifiable health information; and
6. Unless revoked, this Authorization will remain in effect until the earlier of: a) the end of my eligibility as a HIPUtah or Federal-HIPUtah Enrollee; or b) the date that HealthEquity no longer administers my account.

D. IDENTIFYING INFORMATION/SIGNATURES FOR THE APPLICANT

NOTICE: By signing this form, you give SelectHealth the right to disclose health information to HealthEquity about you and your dependents for whom you have legal authority to sign (e.g., a minor child). You do not need to list dependents for whom you have legal authority to sign. Generally, a spouse and children older than age 18 must sign for themselves.

Applicant ______________________________ Date of Birth ______ /______ /______

Applicant Signature ______________________________ **Date Signed** ______ **/**______ **/**______

SELECTHEALTH USE ONLY

HSA Effective Date ______ /______ /______

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