

Health Savings Account (HSA) Enrollment and Authorization to Disclose Health Information to HealthEquity®

Complete this form if you have chosen HealthEquity as your HSA administrator. (See your application/enrollment form.) Please fax your completed form to SelectHealth Enrollment at 801-442-5798. If you have the ability to send secure emails, you can email your completed form to enrollment@selecthealth.org. If you don't complete and send this form, an HSA will not be set up for you. However, failure to complete and send this form will not affect your insurance coverage.

Policyholder's Last Name _____ First Name _____ Middle Initial _____

Social Security# _____ Date of Birth _____

Employer's Name _____

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 employers or health plans. To open an HSA, you must meet three criteria:

1. You must be covered by a qualified High Deductible Health Plan (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 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.

Policyholder's Signature _____ Date _____

B. AUTHORIZATION

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

IMPORTANT PRIVACY INFORMATION

I understand the following information:

1. SelectHealth 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 SelectHealth member; or b) the date that HealthEquity no longer administers my account.

IDENTIFYING INFORMATION/SIGNATURES FOR THE EMPLOYEE/APPLICANT AND DEPENDENTS

NOTICE: By signing this Authorization, 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. **You confirm that each signature below was entered by the actual person or their legal personal representative. If the signature was entered by someone other than the actual person or their legal representative, you may be penalized, including cancellation of your SelectHealth insurance policy.**

Applicant	Date of Birth (MM/DD/YY)	Applicant Signature	Date Signed (MM/DD/YY)
Spouse	Date of Birth (MM/DD/YY)	Spouse Signature or Representative with Legal Authority	Date Signed (MM/DD/YY)
Child with Legal Authority to Sign	Date of Birth (MM/DD/YY)	Child Signature	Date Signed (MM/DD/YY)
Child with Legal Authority to Sign	Date of Birth (MM/DD/YY)	Child Signature	Date Signed (MM/DD/YY)
Child with Legal Authority to Sign	Date of Birth (MM/DD/YY)	Child Signature	Date Signed (MM/DD/YY)



Fair Treatment Notice

SelectHealth complies with Federal civil rights laws. We do not discriminate or treat you differently because of your race, color, national origin, age, disability, or sex.

We provide free:

- > Aid to those with disabilities to help them communicate with us, such as:
 - Sign language interpreters and written information in other formats (large print, audio, electronic formats, other).
- > Language help for those whose first language is not English, such as:
 - Interpreters and member materials written in other languages.

For help with these services, call:

- > SelectHealth Member Services at **1-800-538-5038** (TTY Users: 711)
- > SelectHealth Advantage Member Services at **1-855-442-9900** (TTY Users: 711).

If you feel you've been treated unfairly, call:

- > SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711)
- > Compliance Hotline at **1-800-442-4845** (TTY Users: 711).

You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

Language Access Services

Español

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**.

繁體中文

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**。

Tiếng Việt

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**.

한국어

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**. 번으로 전화해 주십시오.

Diné Bizaad

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'de'ę', t'áá jiik'eh, éí ná hólq', kojì' hódíílnih SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**.

नेपाली

ध्यान दनुहोस्: तपाइंले नेपाली बोल्नुहुन्छ भने तपाइंको नमिति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ | SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**. मा फोन गर्नुहोस्।

Tonga

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**.

Srpsko-hrvatski

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth Advantage: **1-855-442-9900** (TTY- Телефон за особе са отежаним говором или оштећеним слухом: 711) / SelectHealth: **1-800-538-5038**.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**.

Deutsch

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**.

Русский

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth Advantage: **1-855-442-9900** (телетайп: 711) / SelectHealth: **1-800-538-5038**

ةيبرعلا

تدعاسملا تامدخ نإف ،ةيبرعلا تدحتت تنك اذا :تظوحلم
تكرشب لصتا .ن اجملاب كل رفاوتت ةيوغلل
فتاه مقر) SelectHealth Advantage: **1-855-442-9900**
(مكبل او مصل) / SelectHealth: **1-800-538-5038**.

ឌុម្រី

សម្ពាធាៈ ប៊ីសិនជាអ្នកនិយាយ ភាសាខ្មែរ
ស្តាប់ជំនួយជូនកែភាសា ជាយមិនគិតថ្លៃ
គម្រោងមានសរាប់ អ្នក ។ សូមទូរស័ព្ទមក
SelectHealth Advantage: **1-855-442-9900** (TTY: 711)
/ SelectHealth: **1-800-538-5038** ។

Français

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth Advantage au **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**.

日本語

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth Advantage: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**.
まで、お電話にてご連絡ください。