selecthealth

HealthEquity
Building Health Savings

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

Health Savings Account (HSA) Enrollment Form

Complete this form if you have chosen a High-Deductible Health Plan (HDHP), with HealthEquity as your Health Savings Account (HSA) administrator. Please fax your completed form to SelectHealth® Enrollment at **801-442-5798**. Or, you can email your completed form to **individualenrollment@selecthealth.org.** If you have chosen a HDHP and 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.

Subscriber First Name _____ Last Name _____

Subscriber ID _____

A. HSA ENROLLMENT

This form gives us authorization to open an HSA for you. Your HSA is used to contribute funds to pay for qualified healthcare expenses. Even if you change employers or health plans, your account will remain active until you close it and remove all funds. To open an HSA, you must meet three criteria:

1. You must be covered by a qualified HDHP.
2. You generally cannot be covered by another health plan, including Medicare.
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**.

B. COVERED MEMBERS

❑ Add **all family members** currently enrolled on my medical plan to the HSA.

❑ Exclude **all family members listed below** from the HSA.

First Name _____ Last Name _____ Date of Birth _____

First Name _____ Last Name _____ Date of Birth _____

First Name _____ Last Name _____ Date of Birth _____

First Name _____ Last Name _____ Date of Birth _____

First Name _____ Last Name _____ Date of Birth _____

First Name _____ Last Name _____ Date of Birth _____

First Name _____ Last Name _____ Date of Birth _____

First Name _____ Last Name _____ Date of Birth _____

First Name _____ Last Name _____ Date of Birth _____

C. SIGNATURE

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.
3. I certify that I am eligible to open and contribute to an HSA.

Subscriber Name (First, Last) _____

Subscriber Signature _____

Date (MM/DD/YY) _____