



## HSA ENROLLMENT FORM

### Instructions

1. Complete this form in order to open an HSA. (\* = Required Fields)
2. Fax completed form to: Administrative Solutions, Inc. (ASi) at (559) 475-5786 or mail form to P.O. Box 5809, Fresno, CA 93755 or E-mail them to [eligibility@asibenefits.com](mailto:eligibility@asibenefits.com).
3. If you have any questions regarding this form, please call (559) 256-1320.

### Accountholder Profile Information

\*Name (Last, First, MI)

 -  - 

\*Social Security Number

\*E-mail Address

\*Address Line 1 (cannot be PO Box)

\*Address Line 2 (cannot be PO Box)

\*City

\*State

\*Zip

\*Home Phone

 -  - 

\*Daytime Phone Number

\*Date of Birth

Male

Female

\*Gender

Married

Single

\*Marital Status

\*Mother's Maiden Name

\*Hire Date

\*Hours Worked Per Week

\*Payroll Frequency

### Election

Please choose from the following enrollment options:

I am enrolling in an HSA through my employer. My employer will contribute the following amount to my HSA:

\$  on an  annual  monthly  per pay period  other: \_\_\_\_\_ basis.

I also wish to contribute to my HSA through payroll deductions. 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  
or a per pay period election:

\$

Employee Annual  
Contribution

or

\$

Per Pay Period  
Contribution

\*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Your contributions will be withdrawn from your pay in each pay period.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 through the ASi Employee Portal online.

**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.

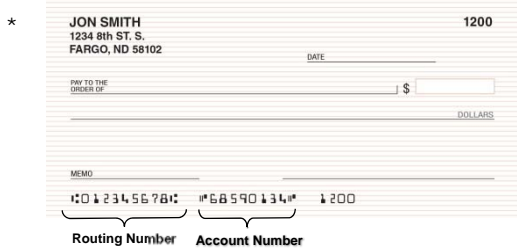
**Direct Deposit Setup**

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

\*Bank Name

                   
 \*Address      \*City      \*State      \*Zip

Checking       Savings              
 \*Account Type      \*Routing Number      \*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="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<input type="text"/>

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

\_\_\_\_\_  
 Date

Subscribed and sworn to before me this  
 \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
 Notary Public