



# Health Savings Account Enrollment Form

## Employee Information

Employer name

First name

Last name

Social security number

 -  - 

Date of birth

 /  / 

Phone number

 -  - 

Marital status

Email

Home address (must not be PO Box)

City

State

Zip code

Mailing address (if different from home address)

City

State

Zip code

## Enrollment Information

I elect to participate in a Health Savings Account

Election Amount (per pay period)

Amount per pay period		x	Number of pay periods	=	Annual election amount
<input type="text"/>			<input type="text"/>		<input type="text"/>

Continue on next page >



**Acknowledgment:** I make this election under my employer's Cafeteria Plan, administered consistent with IRC Sec. 125. By making this election, I authorize my employer to reduce my taxable compensation in order to fund my Health Savings Account. This reduction will be made in equal installments per pay period over the course of the Plan Year.

Employee name:  Date:  /  /   
(type or print name)

Please return the completed form to your HR administrator.

### For Employer Use

Date of hire

 /  / 

HSA effective date

 /  / 

Department/division (if applicable)

Payroll frequency

Payroll deductions begin

 /  /