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HEALTH SAVINGS ACCOUNT ENROLLMENT FORM

CALENDAR YEAR 01/01/2017 – 12/31/2017

GENERAL INFORMATION:

Employee Name					
Mailing Address					
City		**State**		**Zip**	
Email Address					
Social Security Number		**Date of Birth (MM/DD/YYYY)**			
Date of Hire (MM/DD/YYYY)					

☐ I hereby elect to participate in the Health Savings Account

	Per Pay Period	# Pay Periods	Annual Election
Health Savings Account	$ _____	x _____	= $ _____

Effective date of coverage: _____ The first payroll deduction will be on: _____, 2017

My pay schedule is ☐ weekly ☐ bi-weekly ☐ semi-monthly ☐ monthly

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan.

I understand that if requested, I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Health Savings Account for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Health Savings Account Plan. I certify that I will not submit claims for reimbursement under the Health Savings Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

Employee Signature		**Date**	