HSA Enrollment Form

Instructions

New HSA Participants

If you do not currently have an HSA with this Employer, please do the following:

1. Fill out pages 1-3 of this document (*Health Savings Account Enrollment Form*) and return it to your Employer

Continuing HSA Participants

If you already have an HSA with your current Employer, please do the following:

2. Fill out page 4 of this document ó I Ŝl·fűK {I·ØλyƎă ! ŎÖ2dzyű /2yűNλōdzűλ2y˝C2NY˝ú I·yŘ NŜűdzNy˝λű ű2 è2dzN ŜY˝LJf2èŜNJ¢

Health Savings Account Enrollment Form

If you have any questions, please contact EMPOWER Customer Service at (316) 687-3444 or (800) 819-9571.

Part I - Accountholder Profile Information

*Consumer Name (First, MI, Last)		*Employer Name (If sponsored by an employer plan)	
*Birth Date (MM/DD/YYYY)	*Social Security Number	*Home Phone	*Mobile Phone
*Physical Street Address (*U.S. address required to open an HSA*)			
*City		*State	*Zip
Alternate Mailing Street Address or PO Box			
City		State	Zip
*Email Address			
*Gender ☐ Male ☐ Female ☐ Unspecified		*Marital Status ☐ Married ☐ Single	
*Mother's Maiden Name			
*Hire Date	*Hours Worked per Week	*Payroll Frequency	

Part II - Authorization and Eligibility Certification

When opening an HSA with EMPOWER, I understand and agree to the following:

- I am at least 18 years old, not a dependent on someone else's tax return, and not enrolled in Medicare.
- I am covered under a high deductible health plan (HDHP) and I do not have any other health coverage.
- I or my spouse does not have a flexible spending account (FSA) to pay for medical expenses incurred before my medical plan deductible is met, unless it is limited to pay for dental and vision expenses only.

By signing below, I acknowledge that I will log in to EmpowerFlex.com to agree to the terms of the HSA Custodial Agreement. If I am unable to do this, I have requested a copy of this Agreement from my Employer and agree to its terms. I understand that EMPOWER or my employer will accept this Agreement on my behalf.

*Signature	*Print Name	*Date

Part III - Election for Payroll Deduction

(Complete this section if you are enrolling through your employer's benefit offering)

☐ I authorize my employer to deduct my HSA contributions from my payroll, and forward them to my HSA.

My health plan coverage Type: ☐ Single ☐ Family

Note – The HSA has a maximum annual contribution limit that is determined by your health insurance coverage (self-only/family). Your employer may choose to contribute to your HSA, which will count towards to your maximum contribution allowed. Your health plan eligibility determines the effective date of your HSA. If you are covered on December 1, you're considered eligible for the entire year and not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any contributions over the prorated amount may be an excess contribution. You are solely responsible for determining whether contributions to your 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. For additional information regarding eligible and contribution limits please go to: www.irs.gov.

2022 Annual Contribution Limit				**2023 Annual Contribution Limit**		
Health Plan Coverage Level	*Annual Contribution Limit	Per Month		Health Plan Coverage Level	*Annual Contribution Limit	Per Month
Self-Only	$3,650	$304.16		Self-Only	$3,850	$320.83
Family	$7,300	$608.33		Family	$7,750	$645.83

*Age 55+ eligible for an additional catch-up contribution of $1,000

Your Personal Contribution Election

Annual Maximum Contribution (plus catch up if eligible)	Minus (-)	Total Employer Annual Contribution	Equals (=)	Your Eligible Annual Contribution	Divide (/)	Number of Payrolls per Year	Equals =	**Your Maximum Per Pay Period Payroll Deduction**
$ _____		**$** _____		**$** _____		_____		**$** _____

Please withhold **$** _____ from my payroll and apply to my EMPOWER HSA.

Part IV - Debit Card

A debit card will automatically be issued to you to use to make medically qualified purchases from your HSA account.
If you do not wish to have a debit card, then please select below.

☐ I do not wish to have a debit card with my HSA

Part V - Bank Account and Reimbursement Method

When I am not using my debit card and request a distribution through the HSA website, then I select the method below to automatically to receive my HSA distributions.

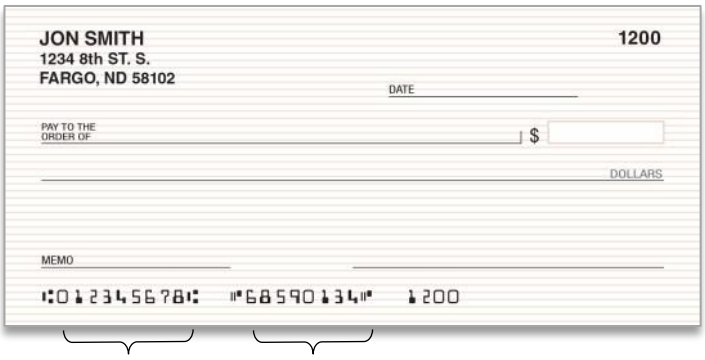
☐ **Paper Check** – I wish to have a paper check mailed to me.

OR

☐ **FREE Direct Deposit** – I wish to have distributions automatically deposited into my personal bank account and will complete the Direct Deposit Setup below. This personal bank account can also be utilized to make a post-tax contribution to your HSA from the HSA website and the HSA mobile application.

Enter your personal bank account information if Direct Deposit selected above.

*Bank Name			
*Address	*City	*State	*Zip
*Account Type ☐ Checking ☐ Savings	*Routing #	*Account #	



YOUR NEXT STEPS:

Step One: Email, mail or fax this completed form to your Employer.

Step Two: Log into my HSA account at the Empowerflex.com Portal (after the HSA's start date) and accept the HSA's Terms and Conditions/Custodial Agreement. If you are unable to do this, request a copy from your Employer (as indicated above, you agree that EMPOWER or your Employer will accept this Agreement on your behalf)

Step Three: Understand that verification of my identity is required for opening an HSA and may result in my being required to supply additional information. If this applies to me, EMPOWER will notify me about how to proceed.

Health Savings Account Contribution Form

This Form is for current HSA enrollees to communicate new year elections

Employer _____ SSN _____

Employee Name _____ Email _____

Hire Date _____/_____/_____ Date of Birth _____/_____/_____

Home Address _____ Work Phone (_____) _____-_____

City _____ State ___ Zip _____ Mobile Phone (_____) _____-_____

Option 1: Health Savings Account

☐ If you have already enrolled for our HSA previously, you do not need to re-enroll. I elect to contribute the following amount for the new Plan Year. Please note that HSA annual maximums include the employee's contributions plus any employer contribution (if applicable).

I elect to contribute $ _____ (before taxes) per Plan Year, which is $ _____ per pay period, to fund my account that pays qualified out-of-pocket healthcare expenses not covered by my employer's health plan or any other health plan.

☐ I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

Option 2: Dependent Care Account

☐ **(Only if offered by your employer)** This is an FSA dependent care account. It pays for days care expenses for a dependent child, adult, or elder, so that you may work. Eligible services include nursery school, nanny, and/or before and after school care through age 12, day care for a disabled adult or child, elder day care for parent or dependent, and day camp through age 12.

I elect to contribute $ _____ (before taxes) per Plan Year, which is $ _____ per pay period, to fund my FSA account that pays qualified dependent day care or elder care expenses.

☐ I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

Option 3: Agreement to Save Taxes on Insurance Premiums

☐ On the appropriate benefit enrollment form, I have enrolled in certain employer-sponsored insurance benefits (i.e., health insurance). I understand that my share of the premium for the employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

☐ I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

Option 4: Additional Benefit

Insert description provided by your HR Department, if applicable: _____

☐ I elect to contribute $ _____ (before taxes) per Plan Year, which is $ _____ per pay period for funding reimbursement of this additional benefit outlined by my Human Resources Department.

☐ I decline this option for this Plan Year and understand that I will lose all tax savings that I could receive as a participant.

IMPORTANT – Please read the following before signing this enrollment form. My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit election set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each plan year, I will be offered the opportunity to change my benefit election for the upcoming plan year. I acknowledge that I have received, read, and understand the Summary Plan Description. I understand that the Card is available to pay only qualified expenses and that qualified expenses paid with the Card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the Card from any other source. I understand that when using the Card, I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my Card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer. For any expenses not repaid by me, I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

I understand that either my employer or its contracted service provider, as applicable, may request that I complete an account application to authorize the establishment of a bank account to enable Flex Benefits Card to access funds necessary for the payment of qualifying expenses, and the payment of qualifying expenses cannot be made without the establishment of such an account. I authorize my employer or its contracted service provider to establish an account for such purpose, and for my employer to authorize the transfer of applicable funds from my payroll to appropriately fund the account in accordance with my previous election(s), and/or to deduct the amount of qualified expenses from the account in settlement of Flex Benefit Card transactions. I further authorize the contracted service provider to have access to my account to complete the settlement of all qualifying trades and transactions, and to have access for customer service purposes to assist in resolving any outstanding claim issues or disputes that should arise on my behalf.

Signature _____ Date _____/_____/_____