Health Savings Account Individual Enrollment Form

0689 (9/20)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Processing may be delayed if fields with an asterisk are not filled out.

Step 1 Consumer information (employee)

* Consumer first name	M.I.	* Last name		
* Date of birth	* Social Security Number	* Day Telephone		
* Permanent address	* City	* State	* ZIP	
* Hire date				
* Email address				

Step 2 High Deductible Health Plan (HDHP) Coverage Level

* HDHP Coverage Level ☐ Single ☐ Family	* HDHP Coverage Date

Step 3 Accountholder Authorization

By signing this application, I represent that: 1) I am covered under a high deductible health plan (HDHP); 2) I am not covered by any other health plan that is not an HDHP; 3) I am not enrolled in Medicare and 4) I cannot be claimed as a dependent on another person's tax return. I understand that if my spouse is enrolled in a general-purpose FSA (a non-HDHP) I am not eligible to contribute to an HSA. I understand that my HSA cannot be effective prior to my HDHP coverage date. I hereby consent that all personal information and selections made are correct. I acknowledge that this form may be electronically signed and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

* Accountholder signature	* Date

Please return to this form to benefithelpsolutions via secure email, or mail.

BenefitHelp Solutions, PO Box 67230 Portland, OR 97268. BHSEligibilityUpdates@benefithelpsolutions.com.