ENROLLMENT FORM*
HEALTH SAVINGS ACCOUNT
(PLEASE PRINT CLEARLY)

245 Kenneth Drive
Rochester NY 14623-4277
Phone: (800) 473-9595
www.BenefitResource.com

Use this form to open and establish a new Health Savings Account (HSA).

EMPLOYER:

EFFECTIVE DATE OF ENROLLMENT: / /

A. EMPLOYEE INFORMATION

Member ID: Social Security Number:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / / Gender: ☐ Male ☐ Female

Hire Date: / / Employee Status: ☐ Full-Time ☐ Part-Time

Email Address: ____

(Note: Your email address will only be used to communicate with you regarding your HSA program.)

B. HSA PAYROLL CONTRIBUTION ELECTION *Please enter your HSA election.*

Contribution Recommendations

- Level 1: Fund to Deductible (Deductible – Employer Contributions)
- Level 2: Fund to Maximum out-of-pocket (Max OOP – ER Contributions)
- Level 3: Fund to Contribution Limit (Contribution Limit – ER Contributions)

I authorize my employer to initiate the following payroll deduction to contribute to my HSA.

Per Pay Deduction $ ______________ **Plan Year Election** $ ______________

IRS Contribution Limits

- For 2018: Single Coverage: $3,450; Family Coverage: $6,900
- For 2019: Single Coverage: $3,500; Family Coverage: $7,000

Additional Catch-up Contribution (for those 55 and older): $1,000

The combination of employee, employer and any third party contributions may not exceed this limit.

C. EMPLOYEE CERTIFICATION & AUTHORIZATION TO ESTABLISH AN ACCOUNT *Please return completed form to your employer.*

☐ By checking this box and signing below, I agree to the following:

- I confirm that I appoint UMB Bank, n.a. to be the custodian for my HSA. I understand that an interest-bearing account will be established in my name. HSA funds in this account will be FDIC Insured up to the legal limits by UMB Bank. I acknowledge that I have received and agree to the terms and conditions governing this account, including the fees and Bank's privacy policy disclosed in the documents. I understand I may access a copy of these disclosures at any time by logging into my account at www.BenefitResource.com or request a copy by contacting Participant Services at (800) 473-9595.
- I authorize Benefit Resource, Inc., my employer and/or their third party service providers to exchange information about my identity, enrollment elections, status and other information necessary to establish my HSA at the Bank, to facilitate direct deposits to my HSA, and to accomplish other purposes related to the payment of healthcare expenses. I agree to indemnify and hold harmless my employer, the Bank, my insurance provider, and their third party service providers against claims or losses that any of them may suffer in reliance on this authorization, and release each of them from any claims or liability based on this authorization.
- I understand that upon enrollment I will be issued a Beniversal® Prepaid Mastercard® for use with my account. If I already have a Beniversal Card for other account benefits, my HSA funds will become available on my existing Card as they become available in my HSA Account and Card Account. I understand that I am responsible for determining if an expense is an eligible medical expense and maintaining proper documentation for tax reporting and potential audit purposes. I acknowledge that my use of the Card will be governed by the Cardholder Agreement that will be sent with the Card.
- I understand the eligibility requirements for contributions made to my Health Savings Account and state that I qualify to make contributions to this account. I assume complete responsibility for:
  1. Determining my eligibility for an HSA each year a contribution is made.
  2. Ensuring all contributions made to my account are within the limits set forth by the tax laws.
  3. Any tax consequences of contributions (including rollover contributions) and distributions.
- I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

Signature: ____ Date: _____ / _____ / _____

D. PAYROLL DEDUCTION INFORMATION *Employer must complete this section for employee to be enrolled.*

- **Deduction cycle:** ☐ weekly ☐ bi-weekly ☐ monthly ☐ semi-monthly ☐ other ________________________________
- **Pay Date of first HSA deduction:** _____/_____/_____
- **Number of pay dates on which HSA deduction will be taken during this Plan Year:** ____

The Beniversal Card is issued by The Bancorp Bank pursuant to a license by Mastercard International Incorporated. Mastercard is a registered trademark of Mastercard International Incorporated. Card accepted at qualified merchants accepting Debit Mastercard. See Cardholder Agreement for the specific details and terms of use of the Card.

HSA Custodial Services are provided by UMB Bank, n.a.; Member FDIC. A separate HSA Custodial Agreement will govern the HSA Custodial Account.