



Enrollment/Change Form

Health Savings Account

Employer Effective Date of Enrollment (MM/DD/YYYY)

Employee Name Hire Date (MM/DD/YYYY)

Member ID (set by your employer. Typically an employee ID or SSN.) Birth Date (MM/DD/YYYY)

Social Security Number (SSN) Email Address

Street or PO Box Phone Number

City State ZIP Employment Status
Full Time Part Time

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

Per Pay Deduction	Plan Year Election	IRS Limits
\$	\$	2020: Single: \$3,550; Family: \$7,100
		2021: Single: \$3,600; Family: \$7,200
		Additional Catch-up Contribution (for those 55+): \$1,000
This is a:		
New enrollment	Change in previous enrollment	

The combination of employee, employer and any third party contributions may not exceed the stated limits.

Please certify the following:

- 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 and (3) that any tax consequences of contributions (including rollover contributions) and distributions.
- I authorize Benefit Resource, my employer and/or their third party service providers to exchange information about my identity, enrollment elections, status and other information necessary 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.

Signature Date (MM/DD/YYYY)

EMPLOYERS ONLY - This section must be complete for employee to be entered into new enrollment

Deduction Cycle: Monthly Semi-monthly Bi-weekly Weekly
 Other:

Pay date of first HSA deduction(s): # HSA Pay Dates this Year:

Submit this document by:

Fax:
(585) 427-9320

Mail:
Benefit Resource, LLC
PO BOX 642
Willow Grove, PA 19090

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