HRC TOTAL SOLUTIONS

Health Savings Account Employer Application (HSA)

Part I. Employer Information

Employer Name: _____

Mailing Address:_____ City:_____ St:_____ Zip:_____

Street Address (if different):_____ City:_____ St:_____ Zip:_____

Phone #:_____ Fax:_____ Tax ID #:_____

Primary Point of Contact:_____ Phone Ext:_____ Email:_____

Secondary Point of Contact:_____ Phone Ext:_____ Email:_____

Billing Point Contact:_____ Phone Ext:_____ Email:_____

Part II. Plan Design

Original Effective Date of Section HSA Plan:_____ Effective Date:_____

What is the annual deductible on the HDHP: Single $:_____ 2 Person $:_____ Family $:_____

What is the annual Employer Funding of HSA: Single $:_____ 2 Person $:_____ Family $:_____

When will Employer submit the HSA funds for deposit?

○ Weekly ○ Monthly ○ Quarterly ○ Annually

Will the Employer allow Employee HSA contributions via payroll? ○ Yes ○ No

Who is your Health Insurance Carrier? _____

Part III. Eligibility

Hours:_____ Length of Service:_____

How many Employees are Eligible:_____ Total Number of Employees:_____

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Part IV. Tax Filing Information

Plan Name: _____

Is this a new plan: ○ Yes ○ No If no, What is the reinstatement Date:_____ _____

Business Structure (Ex. S Corp, C Corp, LLC):_____ State Organized in:_____

Is this a controlled Group: ○ Yes ○ No *(If yes, fill in below)*

Employer 1 Name:_____ Number of Employees:_____

Address:_____ City:_____ State:_____ Zip:_____

Tax ID #:_____ Business Structure:_____ State Organized in:_____

Part V. Signatures and Fees

Broker: _____

Setup/Installation Fee: $_____Account Fee: $_____ Employer Paid Employee Paid

Authorized Signature of Employer:_____ Title:_____ Date:_____ _____

Comments:_____

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