



## HEALTH SAVINGS ACCOUNT EMPLOYER APPLICATION (HSA)

### I. EMPLOYER INFORMATION

Employer Name:		Tax ID #:	
Business Structure:		State Organized In:	
Mailing Address:	City:	State:	Zip:
Street Address (if different):	City:	State:	Zip:
Telephone:	Fax:		
Are there any Affiliated Companies that are also eligible for this benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No			

### II. IMPORTANT CONTACT INFORMATION

Contact Name	Phone #	Email	Type of Contact (check all that apply)	Portal Access
			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Enrollment <input type="checkbox"/> Billing	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Enrollment <input type="checkbox"/> Billing	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Enrollment <input type="checkbox"/> Billing	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Enrollment <input type="checkbox"/> Billing	<input type="checkbox"/> Yes <input type="checkbox"/> No

Broker Agency:			Phone #:	Portal Access
Broker Contact Name	Phone #	Email	Type of Contact (check all that apply)	(to be completed by broker)
			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Account Manager <input type="checkbox"/> Producer	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Account Manager <input type="checkbox"/> Producer	<input type="checkbox"/> Yes <input type="checkbox"/> No



III. PLAN ELIGIBILITY *Please enter the requirements in order for an employee to be eligible for this plan below, as well as some information on how many employees are employed, and eligible.*

Hours worked per week:	Length of employment:
Total # of employees:	Total # eligible:

#### IV. PLAN DESIGN

*Please fully complete the below section to ensure accuracy of plan set up.*

1. Medical Insurance Renewal Month:	2. Deductible Resets: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Plan Year
3. Health Insurance Carrier:	4. File feed for Claims? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. What is the annual deductible on the health plan?	6. What is the annual EMPLOYER funding of the HSA?
Single: \$	Single: \$
2 Person: \$	2 Person: \$
Family: \$	Family: \$
7. At what frequency will the Employer Contribution be made? <input type="checkbox"/> Per Payroll <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Other: _____	
8. Will the Employer allow Employee HSA Contributions via payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Do you want to allow True Substantiation? <input type="checkbox"/> Yes <input type="checkbox"/> No True Substantiation allows HRCTS to Harvest Explanation of Benefits (EOBs) directly from medical, dental or vision carrier's portal on behalf of each employee. HRCTS will then use the EOB data harvested to load claim information to the consumer portal under the expense tracker feature for easy distribution requests. <i>*Please note on True Substantiation that we need to verify your insurance carriers are participating. Additional fees do apply.</i>	



## V. FEES AND SIGNATURES

Please review this application carefully, then please read and sign that you agree to the below fees.

Setup Fee: \$	Per Enrolled Employee	Fees paid by: <input type="checkbox"/> Employer <input type="checkbox"/> Employee	
PEPM Fee: \$		Fees paid by: <input type="checkbox"/> Employer <input type="checkbox"/> Employee	
Minimum Billing per Month Fee: \$			
It is the employer's responsibility to manage and upload all contributions made via payroll to the HRCTS System to initiate the deposit into the individual's account.			
Comments:			
Authorized Signer's Name (print)		Title	Date
Signature:			