HEALTH SAVINGS ACCOUNT (HSA)
2014/2015 PLAN YEAR
ENROLLMENT FORM

Eligibility

SSN:_____ Gender: Male ☐ Female ☐

First Name:_____ M.I._____ Last Name:_____

Employee # :_____ Hire Date:_____ Date of Birth (mm/dd/yyyy)_____

E-mail Address:_____ Telephone (_____)_____

Physical Street Address:_____ City:_____ ST:_____ Zip:_____

Mailing Address (if different):_____ City:_____ ST:_____ Zip:_____

Indicate your desired HSA contribution amount by entering a dollar amount in the space provided.

	PER PAY PERIOD	PER YEAR
TOTAL SALARY REDUCTION:	$_____	$_____

Health Savings Account (HSA):