Simply HSA

Employee Benefits Corporation

Enrollment Form

Submit completed form to your Employer.
Do not submit to Employee Benefits Corporation.
This form is for your Employer's records and allows your Employer to open a Health Savings Account in your name.

General Information

Regis Catholic Schools
Employer/Organization Name

Eau Claire/Altoona
Division

Employee Information (All fields are required)

Last Name | Suffix | First Name | MI

○ M ○ F
Gender

Date of Birth (mm-dd-yyyy)

Date of Hire (mm-dd-yyyy)

Social Security Number (000-00-0000)

Street Address (cannot accept a PO Box) | Apt. No. | City | State | Zip Code

Phone Number (000-000-0000) | Ext. | E-mail Address (we do not share your e-mail address)

My HSA Effective Date

Date I want my account to open (mm-dd-yyyy)

My SimplyHSA Benefits

The total of all contributions made from any source in one tax year to an individual's HSA cannot exceed the IRS maximum (adjusted annually) for the employee's HDHP coverage type. Contact your employer for information on this year's contribution limits.

High Deductible Health Plan Type: ○ Employee-only ○ Family (anything other than Employee-only)

HSA Contributions: I elect to have the amounts below deducted from my paycheck and placed into the following account:

	Employee Contribution per Pay Period	**Employee** Contribution Calendar Year Total	**Employer** Contributions (if any) Calendar Year Total
Pre-Tax HSA Contributions	$	$	$
Post-Tax HSA Contributions	$	$	$
Employee Paid Administrative Fees (if any)	$	$	

Note: Post-tax payroll deductions should only be entered above if an individual is ineligible to make pre-tax contributions to an HSA (for example, a partner in a partnership or more-than-2% shareholder of an S corporation).

Authorization

Please log into your account at www.ebcflex.com after opening your HSA to make Beneficiary Designations or add an Authorized Signer.

○ YES, I WANT TO ENROLL.

By checking this box and signing below, I certify to all of the following:

- All information provided on this form and any attachments, including my Social Security Number, is correct, true and complete as of the date of this signing.
- I am covered, or will be as of the effective start date, by a qualified High Deductible Health Plan. I also certify I am not covered by any other health coverage that is incompatible with an HSA (including, but not limited to, Medicare or a Health FSA), and I am not claimed by anyone else (other than a spouse) as a dependent for tax purposes.
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
- I understand that in the event of a mistaken contribution as defined in IRS Notice 2008- 59, Sections 23-25 my employer may need to request that prior deposited funds be withdrawn from my Health Savings Account in order to correct the error.
- I have reviewed and agree to the following Agreements and Disclosures that have been provided to me for my Health Savings Account: Custodial Agreement, Deposit Account Agreement, Truth-in-Savings Disclosure, Funds Availability Disclosure Agreement, External Funds Transfer Agreement, and the Privacy Statement. I consent to electronic delivery of account statements and understand I can change delivery preferences once enrolled for online access.
- I appoint Avidia Bank as custodian of my Health Savings Account. I understand that I can revoke this authorization of appointment within seven days from the date of opening my HSA by mailing a written notice to Avidia Bank, PO Box 370, Hudson, MA 01749.
- I understand that if I separate employment but choose to retain my Health Savings Account through Employee Benefits Corporation, I will be subject to a $2.50 monthly maintenence fee.
- I am a U S. citizen or other U S. person as defined by the Internal Revenue Service.

○ NO, I DO NOT WANT TO ENROLL AT THIS TIME.

I acknowledge that I have been given the opportunity to enroll in SimplyHSA with my employer on this date and have elected not to do so at this time.
I understand that I can choose to enroll at a later date by providing a new *Enrollment Form* to my employer.

X

Signature

Date (mm-dd-yyyy)

