Health Savings Account (HSA) Enrollment Form

Consumer Driven Healthcare (CDH)

REHN & ASSOCIATES

INSTRUCTIONS

1. Complete this three-page form to open an HSA. **(* = Required Fields)**
2. Return completed document to your Human Resources or Payroll Department.
3. If you have any questions regarding this form, please call (800) 872-8979 or emails us at RehnCDH@rehnonline.com.

Part I - Accountholder Profile Information

***Consumer Name** First, MI, Last		***Employer Name**	
***Birth Date** MM/DD/YYYY	***Social Security Number** XXX-XX-XXXX	***Home Phone** (XXX) XXX-XXXX	***Mobile Phone** (XXX) XXX-XXXX
***Mother's Maiden Name**		***Email Address**	
***Physical Street Address** (*U.S. physical address required to open an HSA*)			
***City**		***State**	***Zip Code**
Alternate Mailing Street Address or PO Box			
City		State	Zip Code
***Gender** Male ☐ Female ☐ Unspecified ☐		***Marital Status** Married ☐ Single ☐	
***HSA Effective Date** MM/DD/YYYY	***Employer Hire Date** MM/DD/YYYY	***Payroll Frequency**	

Part II - Authorization and Eligibility Certification

When opening an HSA with Rehn & Associates CDH Department, I understand and agree to the following:

- **I am a resdisent of the United States of America.**
- **I am at least 18 years old and cannot be claimed as a dependent on someone else's tax return.**
- **I am covered under a high deductible health plan (HDHP).**
- **I am not enrolled in Medicare.**
- **I am not enrolled in TRICARE.**
- **I do not have any other non-qualified health coverage.**
- **I do not have a Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) to pay for medical expenses incurred before my medical plan deductible is met, unless it is limited to pay for dental and vision expenses only.**
- **My spouse, if applicable, does not have a Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) to pay for medical expenses before their medical plan deductible is met, unless it is limited to pay for dental and vision expenses only.**

***Signature**	***Print Name**	***Date**

Typed signatures will not be accepted without an accompanying e-signature verification of authenticity. Handwritten signatures will be accepted without issue.

As a follow-up to this application and upon receiving your enrollment confirmation, you will need to login to the HSA website to accept your terms and conditions.

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Part III - Election for Payroll Deduction
(Complete this section if you are enrolling through your employer's benefit offering)

☐ **I authorize my employer to deduct my HSA contributions from my payroll and forward them to my HSA.**

My health plan coverage Type: **Single** ☐ **Family** ☐

Note – The HSA has a maximum annual contribution limit that is determined by your health insurance coverage (self-only/family). Your employer may choose to contribute to your HSA, which will count towards to your maximum contribution allowed. Your health plan eligibility determines the effective date of your HSA. If you are covered on December 1, you are considered eligible for the entire year and not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any contributions over the prorated amount may be an excess contribution. You are solely responsible for determining whether contributions to your HSA exceed the maximum annual contribution limitation. You are also responsible for notifying the custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution. For additional information regarding eligible and contribution limits please go to: www.irs.gov.

2022 Annual Contribution Limit				**2023 Annual Contribution Limit**		
Health Plan Coverage Level	*Annual Contribution Limit	Per Month		Health Plan Coverage Level	*Annual Contribution Limit	Per Month
Self-Only	$3,650	$304.17		Self-Only	$3,850	$320.83
Family	$7,300	$608.34		Family	$7,750	$645.84

*Age 55+ eligible for an additional catch-up contribution of $1,000

Your Personal Contribution Election

Annual Maximum Contribution (plus catch-up if eligible)	Minus (-)	Total Employer Annual Contribution	Equals (=)	Your Eligible Annual Contribution	Divide (/)	Number of Payrolls per Year	Equals =	**Your Maximum Per Pay Period Payroll Deduction**
$ _____		$ _____		$ _____		_____		$ _____

Please withhold **$** _____ from my payroll and apply to my Rehn & Associates CDH HSA.

Part IV - Debit Card

A debit card will automatically be issued to you to use to make medically qualified purchases from your HSA account.
If you do not wish to have a debit card, then please select below.

☐ I do NOT wish to have a debit card with my HSA.

Part V - Bank Account and Reimbursement Method

When I am not using my debit card and request a distribution through the HSA website, then I select the method below to automatically to receive my HSA distributions.

☐ **Paper Check** – I wish to have a paper check mailed to me. [I understand there may be a per check fee of **$1.50**].

OR

☐ **FREE Direct Deposit** – I wish to have distributions automatically deposited into my personal bank account and will complete the Direct Deposit Setup below. This personal bank account can also be utilized to make a post-tax contribution to your HSA from the HSA website and the HSA mobile application.

Rehn & Associates CDH Department
PO Box 5433 | Spokane, WA 99205
Phone: (800) 872-8979 | Fax: (509) 535-7883 | Email: rehncdh@rehnonline.com

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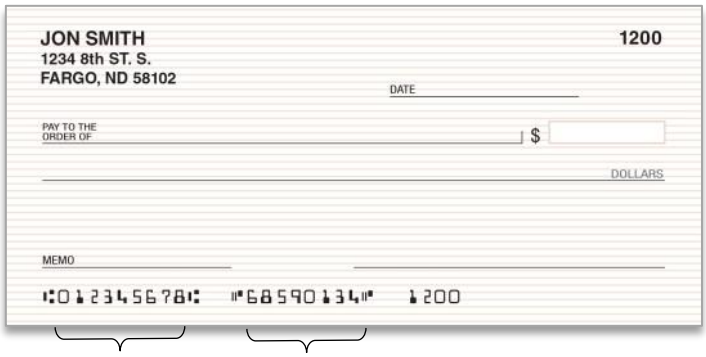
Enter your personal bank account information if Direct Deposit selected.			
*Bank Name			
*Address	*City	*State	*Zip
*Account Type Checking Savings	*Routing #	*Account #	



Routing # Account #

Next Steps:

1. **Email, mail or fax completed form to your employer.**
2. **Upon receiving enrollment confirmation, log into the HSA Portal and accept the terms & conditions of the HSA.**
3. Verification of my identity is required for opening an HSA and may result in needing to supply additional information. If this applies to me, I will be notified by my employer on how to proceed.

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