



## Health Savings Account (HSA) Enrollment Form

Complete this form if you have chosen a High-Deductible Health Plan (HDHP), with HealthEquity as your Health Savings Account (HSA) administrator. Email your completed form to [individualenrollment@selecthealth.org](mailto:individualenrollment@selecthealth.org) or mail the form to the address listed above attention Enrollment. If you have chosen a HDHP and you don't complete and send this form, an HSA will not be set up for you. However, failure to complete and send this form will not affect your insurance coverage.

Subscriber First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Subscriber ID \_\_\_\_\_

### A. HSA ENROLLMENT

This form gives us authorization to open an HSA for you. Your HSA is used to contribute funds to pay for qualified healthcare expenses. Even if you change employers or health plans, your account will remain active until you close it and remove all funds. To open an HSA, you must meet IRS criteria:

1. You must be covered by a qualified HDHP on the first day of the month.
2. You must not already have an active HSA or HRA account.
3. You generally cannot be covered by another health plan, including Medicare.
4. You cannot be claimed as a dependent on another individual's tax return.

These criteria are explained in more detail in the HSA Custodial Agreement available at [healthequity.com](http://healthequity.com).

HSA Effective Date \_\_\_\_\_

The chosen effective date must be on or after the effective date of your medical qualified High-Deductible Health Plan (HDHP). If you qualified for an HSA the first day of the last month of the previous year, you may choose December 1 as your effective date.

### B. COVERED MEMBERS

Add **all family members** currently enrolled on my medical plan to the HSA.

Exclude **all family members listed below** from the HSA.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### C. SIGNATURE

I understand the following about HSA enrollment:

1. By signing this form, I have requested an HSA to be set up in my name with HealthEquity.
2. I have read, understand, and accept my obligations under the HSA Custodial Agreement.
3. I certify that I am eligible to open and contribute to an HSA.

Subscriber Name (First, Last) \_\_\_\_\_

Subscriber Signature \_\_\_\_\_

Date (MM/DD/YY) \_\_\_\_\_

# Fair Treatment Notice

SelectHealth obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

## We provide free:

- > Aid to those with disabilities to help them talk with us. This may be sign language interpreters or info in other formats (large print, audio, electronic).
- > Help for those whose first language is not English, such as interpreters or member materials in other languages.

## Need help? Call SelectHealth Member Services at **800-538-5038**.

If you feel you've been treated unfairly, call SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

### Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth.

통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth. 번호로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yánífti'go Diné Bizaad, saad bee áká'ánída'áwo'd , "ę'ę't'áá jiik'eh, éi ná hólo , 'koji' hódílnih SelectHealth.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth.

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth. まで、お電話にてご連絡ください。

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ጽጋር አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። SelectHealth ጎንገረዱ።

ПАЖИЊА: Ако говорите Српски, бесплатне услуге помоћи за језик, биће вам доступне. Контактирајте SelectHealth.

تنبيه: إذا كنت تتحدث عربي، فستتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بـ SelectHealth.

توجه: اگر بہ زبان را وارد کنی صحبت می‌کنید، خدمات کمک زبانی، بصورت رایگان در اختیار شماست. با SelectHealth تماس بگیرید.

หมายเหตุ: หากคุณพูด ใ้ภาษา, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ SelectHealth

**SelectHealth: 1-800-538-5038**