Health Savings Account (HSA) Application

Please complete all sections. Select True/False where applicable and provide required details.

Qualifying Questions

1. Covered by a high-deductible health plan (HDHP)? True ☐ False ☐
2. Not covered by disqualifying non-HDHP coverage? True ☐ False ☐
3. Not enrolled in Medicare? True ☐ False ☐
4. Not claimed as a dependent on another person's tax return? True ☐ False ☐

Applicant Information

Applicant Name _____ Date of Birth (MM/DD/YYYY) _____

Address _____ Phone Number _____

Social Security Number _____ Email _____

Driver License Number _____ Occupation _____

State of Issuance _____ Employer _____

Expiration Date (MM/DD/YYYY) _____

Issue Date (MM/DD/YYYY) _____

Marital Status

Single ◯ Married ◯ Divorced ◯ Widowed ◯

Plan Type

Individual ◯ Family ◯

Debit Card Requested?

Yes ◯ No ◯

Add Beneficiary?

Yes ◯ No ◯

Beneficiary Information (if applicable)

Name _____ Phone _____

Address _____ Email _____

Social Security Number _____ Occupation _____

Date of Birth (MM/DD/YYYY) _____ Employer _____

Certification

By submitting this application, I certify that the information provided is true and accurate.

Applicant Signature: _____

Date (MM/DD/YYYY): _____