

## Health Savings Account Enrollment Form

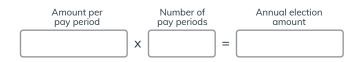
## **Employee Information**

Employer name		Home address (must not	t be PO Box)
First name	Last name	City	State Zip code
Social security number	Date of birth	Mailing address (if differe	ent from home address)
Phone number	Marital status		
Email		City	State Zip code

## **Enrollment Information**

I elect to participate in a Health Savings Account

Election Amount (per pay period)





**Acknowledgment:** I make this election under my employer's Cafeteria Plan, administered consistent with IRC Sec. 125. By making this election, I authorize my employer to reduce my taxable compensation in order to fund my Health Savings Account. This reduction will be made in equal installments per pay period over the course of the Plan Year.

Employee name:		Date:
·	(type or print name)	

Please return the completed form to your HR administrator.

