## **HealthEquity HSA Administration**

**Member Enrollment** 

Employer Name:
By signing this form, I agree to the following:
HealthEquity will establish a health savings account on my behalf. I understand that my enrollment and health information will be shared with HealthEquity for the purpose of administering and coordinating payments under my health savings account.
<ul> <li>I understand that in order to be eligible for a health savings account, I must meet the following criteria:</li> <li>Be covered under a qualified consumer directed health plan, I must be enrolled in one of the CalCPA Health HSA High-Deductible Health Plans.</li> <li>Have no other health coverage except what is permitted as other health coverage by the IRS</li> <li>Not be enrolled in Medicare</li> <li>Not be claimed as a dependent on someone else's tax return</li> <li>Not have access to dollars in a flexible spending account (FSA) that can pay for any medical expenses before the HSAs required deductible is met, including a spouse's FSA.</li> <li>All other criteria listed at this web page: <a href="http://www.healthequity.com/learn/hsa/">http://www.healthequity.com/learn/hsa/</a></li> </ul>
I accept the terms of the HealthEquity HSA Custodial Agreement available at <a href="www.healthequity.com">www.healthequity.com</a> . I understand that as part of the identity verification process, I may be asked to provide additional information and/or documentation before my account can be established. I understand that any applicable monthly HealthEquity HSA administration fees may be deducted directly from my HSA account.
I understand that I cannot use this form to enroll in a medical insurance plan, or to add/remove/change coverage for any dependents. I understand that these changes can be accomplished using the Medical/Dental/Vision Enrollment Form for Employees, or the Employee/Subscriber Change Form, which can be located at www.calcpahealth.com.
Employee Name (Print):
Employee Signature:Date:

Return this form to Banyan Administrators:

Signature of Employer Representative: \_\_\_\_\_\_ Date: \_\_\_\_\_

Name of Employer Representative: \_\_\_\_\_

Email: <a href="mailto:calcpahealth.com">calcpahealth@calcpahealth.com</a> | Fax: (877) 237-4519

Mail: Banyan Administrators, 1215 Manor Drive, Suite 200, Mechanicsburg, PA17055