HEALTH SAVINGS ACCOUNT APPLICATION

☒ **Employer offered HSA (program offered through employer)** Employer name: City of Willmar
- Upon completion, return application to your employer

☐ **Individual HSA (not offered through employer plan)**
- Upon completion, fax application to 651-662-7247 OR fill out your application online at www.SelectAccount.com

Account Holder's Information

Last Name: ______ First Name: ______ Middle Initial: ______

Street Address: ______

City: ______ State: ______ Zip Code: ______

Email Address: ______ Primary Phone: ______

SSN#: ______ Date of Birth: ______

Health Insurance Plan Information	HSA Plan Type
Type of high deductible health plan coverage: ☐ Single ☐ Family Effective Date of Health Insurance Plan______	**If Employer offered HSA:** your employer chooses the HSA plan type, do not complete this section. **Individual HSA:** Elect one of the following options or your HSA will default to Basic: ☐ Premium ☑ Select ☐ Basic ☐ Thrift ☐ Free

Authorization for Electronic Deposit of Contributions and Withdrawals

Bank Information:

☐ Checking or ☐ Savings account

Bank Name: ______ Bank Phone Number: ______

Bank ABA Routing Number: _ _ _ _ _ _ _ _ _ Bank Account Number: ______
(The ABA routing number is the nine-digit number located In the bottom left corner of your check)

☐ **I want SelectAccount to pull $**______from the bank account above

Frequency: ☐ Monthly
☐ One time only

NOTE: HSA Reimbursements will be electronically deposited to this bank account when the HSA debit card is not used.

Signature

The Account Holder named above is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account holder, his or her spouse, and dependents. The account holder represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not entitled to benefits under Medicare (generally, has not reached age 65); and (4) cannot be claimed as a dependent on another person's tax return.

The Custodial Agreement for this account will be sent to you under separate cover.

______ HSA Account Holder Signature ______ Date