EMPLOYER HEALTH EQUITY HSA ACCEPTANCE FORM

ACCOUNT NAME: _____

ACCOUNT #: _____

SALES REPRESENTATIVE / ACCOUNT MANAGER: _____

MEDICAL PLAN (S) EFFECTIVE DATE: _____

LIST PLANS OFFERED THAT ARE HSA QUALIFIED:

_____

_____

_____

☐ USE HEALTH EQUITY AS HSA CUSTODIAN ☐ HSA EFFECTIVE DATE: _____

ACCOUNT CONTACT NAME (PRINT):_____

ACCOUNT CONTACT NAME (SIGNATURE): _____

DATE: _____